

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

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**REPORT OF THE FORTY-FIRST SESSION OF
THE REGIONAL COMMITTEE FOR
THE EASTERN MEDITERRANEAN**

Manama, Bahrain, 2-5 October 1994

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN
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1. INTRODUCTION

The Forty-first Session of the Regional Committee for the Eastern Mediterranean was held in Manama, Bahrain, from 2 to 5 October 1994. The inaugural meeting was held at the Bahrain International Exhibition Centre. The regular session was held at the Regency Intercontinental Hotel. The Session was attended by Dr Hiroshi Nakajima, Director-General of the World Health Organization.

The Technical Discussions on the "Role of the Community (including NGOs) in AIDS Prevention and Control Activities" were held on 3 October.

The following Members were represented at the Session:

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

In addition, observers from Algeria and India, as well as representatives of the United Nations Children's Fund, the United Nations High Commissioner for Refugees, the United Nations Development Programme, the United Nations Environmental Programme, and the United Nations Relief Agency for Palestine Refugees in the Near East, Health Ministers' Council for Gulf Cooperation Council States, the League of Arab States, the Organization of African Unity and of a number of nongovernmental and national organizations attended the Session. (See Annex 2 for full list of participants).

2. OPENING MEETING AND PROCEDURAL MATTERS

2.1 Opening of the Session by H.E. the Minister of Health of the Islamic Republic of Iran

Agenda item 1

His Excellency, the Minister of Health and Medical Education of the Islamic Republic of Iran, Dr Alireza Marandi, the Chairman of the Fortieth Session of the Regional Committee, opened the Forty-first Session and welcomed the participants, and thanked the State of Bahrain for hosting the meeting.

Dr Marandi reflected that the Eastern Mediterranean Region was in many ways different to those in other regions of WHO. One of the differences was the common culture and the belief in Islam shared by the majority of its peoples, leading to a strong social bond between countries.

He commented that the past year had, in terms of health progress, been a fruitful one for Member States, and he was certain that this would be reflected in the Regional Director's Report. Furthermore, the results of the Third Monitoring of Progress of Strategies for Health for All by the Year 2000, to be presented during the Session, would also show the positive results achieved in implementing the programmes in the past three years.

Yet some problems that needed urgent attention remained. Malaria and tuberculosis still threatened lives and the threat of AIDS was growing. Furthermore, many diseases, including diarrhoeal diseases, continued to endanger the health of children.

The high rate of population growth and economic problems had made it difficult to coordinate health and development programmes, and this had in some cases been made worse by internal unrest and interference from outside. Additional problems were caused by health manpower limitations, both in terms of number and quality, and the fact that medical education was still cure-oriented. It was necessary, he said, to promote community-oriented medical education and seek greater participation of the people.

He encouraged Member States to make use of the Sessions of the Regional Committee to further cooperation aimed at identifying common problems, and so that technical representatives could meet to analyse and solve those problems that had been identified. He stated that it was necessary to depend on the countries' and region's own resources in order to achieve self-sufficiency.

In calling for adherence to the traditions of the Region, setting aside foreign cultural influences, he cited the temptation to use infant feeding formulas rather than practice breast-feeding. It was important to adhere to established moral principles and to respect the sanctity of the family as an institution.

In closing, he thanked the Director-General, the Regional Director and the staff of WHO for their continuing support, and wished the meeting well.

2.2 Address by the Minister of Health of Bahrain

His Excellency the Minister of Health of Bahrain, Mr Jawad Salim Al-Arayed, welcomed the participants, and expressed his country's pleasure in hosting the Forty-first Session of the Regional Committee. He conveyed greetings from His Highness the Emir of Bahrain, His Highness the Prime Minister and the Crown Prince, and their best wishes for the success of the Session. He also thanked Dr Hiroshi Nakajima, Director-General and

Dr Hussein A Gezairy, Regional Director, for their continuing efforts in responding to the health needs of the countries of the Region.

His country's health strategy reflected that of WHO and his government had adopted the Global Strategy for Health For All by the Year 2000. With the support of its national political leadership, his country would be able to achieve its health strategy. Comprehensive health services were available to every citizen and resident of Bahrain; clean water reached every home; essential drugs were available in all health centres; primary health care services covered all parts of the country. Bahrain was giving the utmost attention to the Expanded Programme on Immunization (EPI) and most EPI-target diseases had been nearly eliminated.

Bahrain's health strategy depended on cooperation with both governmental and nongovernmental organizations, through which major achievements had already been realized. Health had become an integral component of national comprehensive development projects.

His Excellency Mr. Al-Arayed spoke of the diseases that burdened many countries of the Region which were related to unhealthy lifestyles such as AIDS, cardiovascular diseases and diabetes, which his country, along with other countries of the Region, was doing its best to fight. He added that the countries of the Region also had to be prepared to confront any health emergency that might occur in any part of the world. A recent example was the outbreak of pneumonic plague in India. He called for the coordination of plans made in response to such emergencies.

He called on the countries of the Region to utilize new techniques in health research and planning, and to evaluate the far-reaching positive effects of applying primary health care policy to reduce infant and child mortality. In the coming decades, he expected these positive effects to lead to major changes in population structure, including an increase in the proportion of the elderly. Such changes would lead to a great increase in the demand for health services.

Mr Al-Arayed referred to the increasing involvement of the private sector in providing health services. This trend required countries of the Region to create a market to encourage this sector and to ensure that privatization did not lead to the provision of low quality health services or the reduction of health service coverage.

In conclusion, the Minister of Health of Bahrain called for serious efforts in achieving health for all by the year 2000, and for this movement to continue into the twenty-first century.

2.3 Address by the Regional Director

Dr Hussein A. Gezairy, the Regional Director, welcomed all delegates and expressed his pleasure at the revived tradition of holding sessions of the Regional Committee in alternate Member States, particularly thanking His Excellency Mr Jawad Al-Arayed, the Minister of Health for Bahrain, for hosting the meeting.

He emphasized the importance of health as a means of achieving peace in the world. He supported this postulate, citing the approval of the warring factors in Afghanistan of a period of tranquillity which would permit the immunization campaign to cover the entire country.

He expressed pleasure at the formation of the Palestinian Health Authority, which had been anticipated by the Eastern Mediterranean Regional Office well before the autonomy

agreement had been signed, when he had convened a meeting for the formulation of a national plan of health several months earlier.

Referring to the recent International Conference on Population and Development, held in Cairo, he spoke of the attempts made by a handful of industrial states to impose their own values on billions of human beings, thus exposing other nations to the same ills from which they themselves suffered, and which were a consequence of the weakening of the family in their own societies, the secure cradle which guaranteed a sound upbringing for young children and equipped them to resist the temptation of drugs, promiscuity and violence. He commended the positive contribution of political and spiritual leaders of different religions and creeds who had the opportunity to present the moral values cherished by believers throughout the world.

He emphasized the importance attached to the family by all the nations of the Region. He emphasized the importance of the family, in particular the role of the woman in ensuring its stability and the health of its members, and, by extension, the role of the family in contributing to social stability and betterment in the community. He commended the contributions of political and spiritual leaders who upheld the beliefs in family and community values so dear to this Region. This moral stance was important not only to combat the dissolution of the family, which led to social and mental problems, but also in the battle against diseases resulting from sexual promiscuity. He pointed out that the family as viewed by the Region meant a husband and wife, united by a legal bond of marriage, enjoying an atmosphere of mutual love and compassion, providing care for those who were close of kin, males and females, young and old, offspring and elderly. They establish a home where women are men's counterfoils, and they conduct their affairs in a congenial manner which promoted all that is good and beneficial. In such a family home the woman is also a shepherd providing physical, mental and educational care for the rest of the family. At the same time, she plays an all-important social role, enjoining what serves the common good, and speaking out against social evil. Like man, she walks along the byways of the earth and eats of what God has provided for us; and like man, she goes about her work, hoping for God's bounty and making her contribution to building civilization and developing her community.

It is to build the structure of the family on a solid foundation, and to spare young men and women unnecessary exposure to the diseases that are rampant in pseudo-civilization, particularly those which are transmitted through promiscuous sex, that we in this Region advocate early marriage.

Marriage establishes a home where mutual love and compassion blossom, which is the best environment to promote mental health. When we advocate early marriage, he said, we are only speaking of marriage at the right time for both man and woman, when each of them has reached the proper stage of physical and mental development. We do not countenance the premature marriage that takes place in some underdeveloped communities where marriage contracts are made even before the couple have attained puberty.

He expressed amazement at the so-called advanced societies as they view, at least with silent approval, sex at an early age, only when it comes through an illegitimate relationship. Yet they are quick to voice their strong opposition when such a relationship is legitimately established between the same people, at the same age.

In this connection, he spoke in glowing terms of the historic resolution approved this year by the World Health Assembly which censured premature sexual relations. He would have liked this stand to be clearly outlined at the Conference on Population and Development, instead of attributing to the World Health Organization an erroneous definition of reproductive health

that had not been presented either to the Executive Board of the World Health Organization or the World Health Assembly. Hence, such a definition does not represent the view of the World Health Organization.

Dr Gezairy stressed that as we advocated marriage at an early age, we also advocated family planning for health. This highly appropriate phrase was used in a resolution adopted by the World Health Assembly last year. Hence, it represented WHO's official view. The World Health Organization attached great importance to the health dimension of family planning which meant the avoidance of pregnancies that were too early, too late, or too frequent. Early marriage protected and promoted the sexual and mental health of young men and women. Family planning for health promoted the physical well-being of both mother and child. The woman must receive a reasonable standard of health education, and she must understand that it is her duty to ensure that her children are immunized at the right time. It is the mother who teaches her children healthy eating habits. She imparts positive attitudes to health, steering her children away from exposure to risks that threaten their physical and mental well-being. The mother should be able to oversee the full health care of her family, making sure that all members of the family have the maximum degree of health protection and disease prevention, taking steps to ensure the early detection of illness and administering any medication prescribed by the family doctor. When all this has been ensured women can play their full role in society and make their voice heard in the development of the community.

In speaking about the world more generally, Dr Gezairy commented on the effect of the ending of the Cold War and the reduction of the role of the public sector in the area of health. He called on the private sector to take both greater responsibility and greater interest in lower profile areas such as environmental health, immunization, health education, other aspects of health protection and promotion and disease prevention.

He particularly commended Prime Minister Benazir Bhutto for her speedy response to his appeal to reverse the deteriorating trend in polio immunization in Pakistan. He also thanked His Highness Sheikh Zaid Bin Sultan Al Nahyan, President of the United Arab Emirates, and the Canadian government for their financial support of the immunization programme in the Region.

The Regional Director was pleased that most countries of the Region were making steady progress towards achieving the goal of eradication of polio by the middle of this decade. He observed with satisfaction that the Region had two geographical areas, each grouping several Member States, which had almost attained the goal of polio eradication, to be closely followed by a third area. He appealed to all benevolent people to support the polio eradication initiative.

In considering many communicable diseases, he noted that some diseases may re-emerge after having lain dormant. Plague was the clearest example. Having disappeared from the Indian subcontinent for nearly 30 years, it had re-emerged in a most worrying way, because the outbreak was mainly of the pneumonic type. It was a major preoccupation of Member States of the Region, many of which, through regular population movement, had very close ties with India.

The Regional Director mentioned that the State of Bahrain, where the Regional Committee was meeting, had been the first country to implement the Action-Oriented School Health Programme, and thanked the Minister of Education for offering a programme showing details of this pioneering experience.

In conclusion, the Regional Director welcomed His Royal Highness Prince Abdul Aziz Bin Ahmed Bin Abdul Aziz Al-Saud, Regional Chairman of the International Agency for the Prevention of Blindness who had kindly agreed to address Regional Committee members on the subject of the prevention and control of blindness in the Region. (See Annex 3 for full text).

2.4 Address by the Director-General of WHO

In his address, Dr Hiroshi Nakajima, Director-General of WHO, said that during the current year the governing bodies of the Organization had been focussing on reform in the regions, and, that by the end of the year, all regions should have designed and started implementing what, in the global reform process, pertained to their own areas of competence and authority. In 1995, these governing bodies would expect a report on the progress and harmonized reform process in the Regions from the Regional Directors. Much of the final success of WHO's reform process was now in the hands of the regions and regional committees.

The Director-General said that, for some countries, the overall economic situation was precarious and it was likely that least developed countries would continue to experience economic hardship and its social consequences. At the present time of uncertain economic prospects, rich and poor countries alike were facing increased costs in the social sector — particularly in health, resulting in governments looking for opportunities to enforce stringent economies. As a consequence, WHO itself had been affected by shortfalls in contributions and a zero growth budget in real terms. The prospects of the situation improving in the near future were not encouraging. The shift in the role of the United Nations towards the management of complex emergency and humanitarian situations had greatly added to WHO's operational and financial responsibilities.

It was conceded that the United Nations, in its effort to focus on better coordination, efficiency and value for money, had to some extent, lost the vision of its role in socioeconomic development. People, particularly taxpayers in major donor countries, were showing less interest in the United Nations specialized agencies than in nongovernmental organizations that now had a total budget ten times greater than that of the whole United Nations system. However, the World Bank had recently recognized the significance of supporting investment in health as a component of the "structural adjustment" process.

WHO had to demonstrate accountability in this climate of fierce competition for funding at the international as well as at the national level. Unless a better case was made by the health sector, it would lose out and funding would dry up. He cited the example of malaria which was able to make a comeback because it did not get sufficient public attention and external donors did not consider it a priority. Today's priorities, if left unattended, might become emergencies of tomorrow.

He was pleased to note that, during the previous year, despite severe constraints on staff and budget, it had been possible to achieve encouraging results in a number of important fields. The most important one, outside the health sector but with major implications for the lives, health and welfare of all the peoples of the Region, had been the historic peace accord and the implementation of self-rule in Gaza and Jericho which opened a new era of peace, cooperation and development. WHO was stepping up its technical cooperation activities in support of the development of a comprehensive health care system for the Palestinians.

Turning his attention to disease control, Dr Nakajima stated that the first International Conference on Elimination of Leprosy, held in Viet Nam in July 1994, had adopted the Hanoi

Declaration which called for stronger political and financial commitment to the goal of leprosy elimination. With the introduction of multidrug therapy nine years ago, the total number of cases worldwide had been reduced by 70%; in 1994 alone, the number of cases dropped by 23%. The target of eliminating leprosy as a public health problem by the year 2000 was now well within reach, and, in order to accelerate progress, a special programme was to be set up.

Similarly, steady progress had been made at the global level towards the goal of eradication of poliomyelitis by the year 2000. While the 24% increase in polio incidence reported for 1993 for the Eastern Mediterranean Region was to be viewed with concern, it also had to be recognized that this was an indication of great improvement in the epidemiological surveillance systems. Efforts would now have to be intensified to reach remote and marginalized groups.

Dr Nakajima then referred to the Summit of the Organization of the African Unity held in Tunis in June 1994 which placed the issue of Children and AIDS in Africa on its agenda and emphasized the importance of extending prevention efforts, in particular to the young and within the family environment.

The tenth International Conference on HIV/AIDS and Sexually Transmitted Diseases held in Yokohama, Japan, in August 1994, had called attention to the rapid spread of the pandemic in South and South-East Asia. The Conference had confirmed WHO's leading role and unique competence in the global fight against HIV/AIDS. Within the United Nations Joint and Cosponsored Programme on HIV/AIDS, WHO would maintain this leadership and its constitution responsibility for directing and coordinating international health work. An AIDS Summit would be convened in Paris, on 1 December 1994, under the cosponsorship of France and WHO.

Dr Nakajima referred to the declaration by WHO in 1994 of tuberculosis as a global emergency. It was currently estimated that worldwide the disease killed about 3 million people each year. The HIV/AIDS pandemic had contributed to boosting the global threat of tuberculosis. Other important factors had been the poor quality and underfunding of many national control programmes, poverty, uncontrolled urbanization, breakdowns in drug supply, etc. It was imperative that efforts at control gain the upper hand while short-course chemotherapy should provide a highly cost-effective tool for control of the disease. He cautioned against missing this opportunity and giving drug resistance a chance to develop.

Health was both a major determinant and an outcome of development. Sustainable and integrated health development required solidarity, both at national and international levels, but countries needed to finance priority areas. New social and economic structures, especially increased privatization, called for new approaches to health management and cooperation. The Director-General gave assurances that WHO would continue to promote partnerships for health involving all social and professional sectors.

The nature and scope of people's participation in health development had changed considerably since the Declaration of Alma-Ata in 1978. Nongovernmental organizations, communities and patients themselves were playing an increasingly active role in advocacy and political lobbying, as well as disease prevention, health care and rehabilitation.

Health for all remained WHO's basic goal. Equity in access to health care remained a responsibility of governments and was the fundamental issue of health ethics as was emphasized at the Forty-seventh World Health Assembly in 1994. But, it was recognized that

the equitable provision of health care required the participation of a far wider spectrum of providers and beneficiaries than had been originally envisaged at Alma-Ata.

In conclusion, Dr Nakajima said that the new partnership would be founded on this new ethical vision. Respect for the dignity and rights of individuals, whether sick or healthy, was the starting point. Informed responsibility on the part of individuals within their families and communities was also of vital importance. A health care system developed by the government should be at the centre of the national development policy. Involvement and commitment at the highest political level of the State, supported by the people, were of the utmost importance in establishing this new partnership in health. WHO would continue to extend its technical cooperation at all levels to support the efforts to achieve health for all, and **health by all**, to prepare for the twenty-first century. (See Annex 4 for full text).

2.5 Election of Officers

Agenda item 2, Decision 1

The Regional Committee elected the following officers:

Chairman	Mr Jawad Salim Al-Arayed (Bahrain)
First Vice-Chairman	Dr Mustafa Kamal El Baath (Syrian Arab Republic)
Second Vice-Chairman	Mr Manolis Christofides (Cyprus)

Dr Ahmed Bin Abdul-Kader Al Ghassany (Oman) was elected Chairman of the Technical Discussions.

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

Dr Moncef Sidhom (Tunisia)
Dr Fawzi Abdalla Arneen (Bahrain)
Dr M.H. Wahdan (EMRO)
Mr H.N. Abdallah (EMRO)

It was so agreed.

2.6 Adoption of the Agenda

Agenda item 3, Document EM/RC41/1, Decision 2

The Regional Committee approved the Regional Director's proposal that an additional item, "The present status of plague and methods of control", be included in the Agenda.

The Regional Committee adopted the Agenda of its Forty-first Session as amended.

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 1993

Agenda item 4, document EM/RC41/2, Resolution EM/RC41/R.2, Resolution EM/RC41/R.3

The Regional Director, Dr Hussein A. Gezairy, presented his Annual Report for 1993, The Work of WHO in the Eastern Mediterranean Region, and mentioned some of the highlights of the past year.

The year 1993 had been difficult in the Region, marked by civil strife and epidemics. WHO/EMRO had responded to these changing needs by adjusting programmes, raising extrabudgetary funds, encouraging emergency preparedness and response programmes, and opening WHO suboffices in devastated areas. The Regional Director recalled a pioneering experience of the WHO Office in Afghanistan, where WHO had worked together with the Ministry of Health to relocate and reopen the Faculty of Medicine so that training of health personnel could continue.

Dr Gezairy welcomed the delegates of Palestine and looked forward to future reports on the health status of the Palestinian population, in their homeland and diaspora, and on the ongoing activities and cooperation between WHO and the national authorities in the liberated areas as a start, then in the State of Palestine to be established, God willing. He thanked all countries of the Region for contributing to the new Palestinian health budget, which was being treated as any other, with a Joint Programme Review Mission to support sound planning and programming. He hoped that the direct involvement of Headquarters in channelling resources was transitional, and that future dealings with WHO would be instituted through the Regional Office.

In reviewing the activities of the past year, Dr Gezairy underlined the continuing success of the Basic Minimum Needs (BMN) approach in Primary Health Care, (PHC) which had been reported to and supported by the Regional Committee in 1993.

Health for all depended largely on the availability of well trained health personnel. In particular, the nursing situation in the Region was being reviewed and postgraduate training programmes in health manpower development were being introduced.

The Regional Director pointed out that six new collaborating centres had been designated in the Region in 1993. He reminded the Regional Committee of its 1993 resolution requesting¹ WHO to allocate part of the Secretariat's budget to financing "floating" posts in a number of such centres, so that they would place their most skilled experts and the most recent achievements of science at the disposal of WHO, and by extension to the countries, whenever the need arose.

He suggested that Ministries of Health conclude contracts with specialists working in other sectors in the country, especially in universities, or even those working in the private sector, to undertake research with a view to analysing health status, solving emergent health problems, devising useful health initiatives or rationalizing health actions.

A major role of WHO had always been to help countries become self-sufficient in essential health services. He pointed out that self-sufficiency in this respect did not only apply to

¹ EM/RC40/R.15.

the development of the human resources needed for the health system, but also to the production by the countries of the Region - singularly or collectively - of their own essential vaccines, drugs, essential equipment and reagents needed for laboratory and radiological diagnosis. He cited as an example of self-sufficiency the salt iodization programmes aimed at the prevention of iodine deficiency disorders.

Health care services could only be as good as the facilities that supported them. Where a few years ago there had been no programmes on quality assurance in laboratories in the Region, now 14 countries were establishing national programmes in 1994. The Regional Office continued to provide support for the development and expansion of health laboratory services, especially at the peripheral level and in rural areas.

The Regional Office continued to support efforts to develop national blood transfusion services in countries of the Region, with the overall aim to ensure the provision of sufficient supplies of safe blood, blood components and blood products based on voluntary regular nonremunerated blood donations. The Regional Blood Transfusion Centre in Tunis regularly conducted courses in different aspects of blood transfusion, leading to a recognized diploma.

The Regional Director mentioned with great pride, certain achievements in this area. EMRO had produced several technical manuals covering important areas in the field of Laboratory Medicine and Blood Transfusion Medicine. So far, five publications had been issued. Among the subjects tackled were: principles of management of health laboratories, quality assurance in health laboratories, laboratory facilities in emergencies and disasters, production of essential reagents for laboratories, blood transfusion, preparation of blood grouping reagents, and blood transfusion and blood components. Two manuals, one a guideline for establishing total quality management in health laboratories, and another, on the collection of microbiological specimens, had been finalized and were expected to be available by the end of this year. In recognition of global appreciation, EMRO had agreed to requests to translate a number of these publications into several languages.

The Regional Director called attention to attempts made by some manufacturers of biologicals to infiltrate quantities of anti-D immunoglobulin-containing products with positive reaction to hepatitis C into some countries of the Region. He urged Member States to insist on proof from the original producers of blood products that the blood used in their preparation was confirmed as negative to all blood-borne disease-causing agents, and that the use of those products was sanctioned in the country of origin.

In reviewing other areas of the programme, Dr Gezairy noted that maternal mortality rates continued to be high in six countries of the Region and very high in six others. He emphasized that priority had to be given to the health status of women. It was gratifying to note that the Safe Motherhood Programme had become a high priority programme in the Region and that woman's health was being considered in the light of her entire life span, not only during the childbearing years.

Immunization coverage for the six EPI diseases had dropped significantly in some countries in 1993, mainly due to shortages of vaccine. The EMR long-range plan for self-reliance and quality control of vaccines will be the only reliable means of overcoming such shortages in the future.

The Prototype Action-Oriented School Health Curriculum for Primary Schools was being applied by several countries as a means of providing health education for schoolchildren.

The pattern of diseases in the Region was shifting from communicable to noncommunicable diseases as a result of changing lifestyles, a higher proportion of elderly within the population, and the new affluence. The Regional Office had recently published guidelines for the prevention and control of diabetes and tobacco control legislation had been issued in all Member States.

In the last four years, the Health of the Elderly Programme had progressed rapidly and most EMR countries had undertaken situation analyses. In this context, the Regional Office had prepared a regional strategy and had published a manual for community health workers. A joint EMRO/SEARO meeting was being planned for the end of 1994.

Dr Gezairy noted that AIDS prevention and control continued to be supported, technically and financially, by voluntary funds. In 1993, 577 new cases of AIDS had been imported in the Region. The Regional Director emphasized the importance of the involvement of non-health sectors and said that the Regional Office was giving high priority to the dissemination of information on AIDS. He expressed concern about the latest developments regarding the administration of the Global Programme on AIDS and its conversion into a joint United Nations programme and invited the Director-General to brief the Regional Committee on his recent meetings regarding this new programme.

At least 10 countries in the Region had suffered outbreaks of cholera; such incidents could only be prevented by ensuring a healthy environment. Following WHO's Global Strategy on Health and Environment, the Regional Office established a regional strategy, approved by the Regional Committee in 1993. He gave instructions that the entire potential of EMRO should be mobilized to put this strategy into execution, including the intensification of efforts exerted by CEHA in Amman, and the reorientation of such efforts towards more effective involvement in solving environmental health problems in the countries of the Region. Dr Gezairy urged Member States to take advantage of the capabilities of CEHA in providing training, advising on solving environmental problems, and promoting "healthy cities, healthy villages and healthy communities" programmes.

Turning his attention to the 1994 session, Dr Gezairy stated that the Regional Committee would be discussing the budget for 1996-1997. Accounts for the 1992-1993 biennium had been closed with obligation of the full amount of US\$66 million from the Regular Budget and an additional US\$26 million in extrabudgetary funds. In 1993, a total of 209 short-term consultants in 1993 (59% from the Region) had carried out a variety of activities and 62 meetings had been held. There were 528 fellowships awarded, slightly less than the previous year, due to instability in some countries.

Dr Gezairy referred to the Voluntary Fund for Health Promotion, established some years ago to provide support for several innovative initiatives and health programmes of a developmental nature. The funds available to the Fund were insufficient for the great demand. He invited participants to seek, each in his personal and/or official capacity, the provision of additional resources to that Fund. He called upon them to work for the establishment of resource mobilization organization to support WHO programmes.

He touched upon health statistics and its role in rationalizing the use of the limited resources available to various countries. He had decided to replace the existing limited posts at EMRO with the post of a health statistics technical officer in the Health Policy and Administration Division, which would be at the disposal of Member States, giving them advice in this important field.

The Regional Director, supported by Dr Alireza Marandi, Chairman of the Fortieth Session of the Regional Committee Session, requested that the topic of Ethics of Medicine and Health be considered for discussion at a future session of the Regional Committee. In closing, Dr Gezairy emphasized the continuing efforts being made to improve the health status of peoples in the Eastern Mediterranean Region.

Discussion

Representatives commended the Regional Director for his Annual Report, stating that it was a comprehensive and exhaustive document, covering various health and health-related problems, issues and conditions. In addition, it included a great deal of information, and detailed accurate and varied data, thus highlighting the efforts exerted by the Regional Office to promote the health of the people in the Region.

The Representative of Palestine expressed deep appreciation for the support provided to the Palestinians by the Director-General, the Regional Director and the various countries of the Region. He went on to say that, in view of the breakdown of the health infrastructure and facilities as a result of the occupation, he was earnestly calling upon WHO and its Member States to continue to provide assistance and support to Palestine. He requested that WHO Offices be established in Palestine to facilitate the implementation of the programme of work that had been developed, and that attention be given to meeting the urgent needs of the Palestinians living in Lebanon, Jordan, the Syrian Arab Republic and Egypt. He also appealed to WHO and the countries of the Region to support the Palestinian Red Crescent Association.

The Representative of Tunisia commended the basic minimum needs and community participation approaches which contribute to the implementation of PHC activities, and the cost-effectiveness of programmes of health in the Region. He requested that laboratories be supported and their capabilities developed in the field of vaccine production. He also praised the training activities organized by the Regional Office and emphasized that attention should be given to updating health legislation, focussing on medical ethics, promoting coordination and the exchange of information among countries, and providing support to the Palestinian people so as to reconstruct the health infrastructure at this important stage of their history.

The Representative of Afghanistan thanked the Regional Director for the continued support provided to Afghanistan during the years of civil strife, and particularly for initiating mass immunization campaigns. A number of donors contributed to the successful immunization programme. The Islamic Republic of Iran had made a generous contribution of polio vaccine.

The civil war of 17 years had devastated the infrastructure of the country and this included public health services. The activities of the Ministry of Public Health were based on humanism, neutrality and impartiality. Health services were provided to all irrespective of their religion, political alignment or clan. Health workers were also victims of war and many of them died while providing services. In conclusion, he called for understanding and support by all Member Countries of the Region.

The Representative of the Islamic Republic of Iran said that, in view of the fact that each country had its own specific needs and problems, he called on the Organization to assist in finding ways to reduce the dimensions of those problems. International, multilateral and bilateral agencies, developed countries, and others could contribute considerably in this regard. Member States of WHO should also intensify their own efforts to meet their needs and solve problems.

The Representative of the Libyan Arab Jamahiriya indicated that the Annual Report had made no mention of the severe health effects of the embargo imposed on his country, and requested the Regional Committee to use its influence so that the United Nations General Assembly issue a resolution lifting the embargo on drugs and medical supplies. He recalled the Assembly's resolution 39/210 emphasizing that developing countries should not try to impose trade restrictions, embargo or any sanctions. He also recalled resolution WHA41.31 as well as the principles stipulated in decision EB81(3) rejecting any embargo on medical supplies for political reasons.

The Representative of Sudan described the deteriorating health situation in Sudan due to the heavy rainfall and floods which had devastated health facilities and agricultural schemes, as well as the poor environmental conditions. This had led to malaria breakouts throughout the year; he noted that there were from 10 to 15 million malaria cases. Activities focussed on controlling the water stage of the vector, drying up of dumping ponds, case-finding and treatment and health education situations. He thanked the Regional Office for its assistance in the form of short-term consultants as well as supplies and equipment and hoped that the Regional Director's recent visit to Sudan would soon bring fruitful results. Sudan suffered from other problems of water-borne diseases, such as schistosomiasis. He expressed sincere thanks for the support His Royal Highness Prince Abdul Aziz Al-Saud for blindness control activities in Sudan.

The Representative of the Republic of Yemen thanked the Regional Director for his support, especially during the recent civil war which had caused severe destruction to the health infrastructure, the basic health services and the water supply systems. Health care coverage, particularly immunization coverage had declined seriously. He urged WHO as well as other United Nations agencies to extend their assistance to face this difficult situation.

The Representative of Morocco noted the high rates of maternal and perinatal mortality, which should receive more attention. He said that a Regional plan for safe motherhood should be formulated and support should be provided for countries with urgent needs in this respect. To address the high costs of health services, particularly hospitalization, steps should be taken to rationalize the use of the limited resources available for the health sector and avoid wasting resources, rather than seeking additional resources and increasing the health sector budget. He commended the establishment by the Regional Office of a post of Regional Adviser for Health Economics and called for the support and advocacy of health economics concepts.

The Representative of Iraq described the deterioration of the health situation in his country where infant and under-five mortality had recorded high rates. This situation had resulted from the lack of resources necessary for the implementation of health plans and programmes. There was widespread malaria, cholera and hepatitis. There was also an urgent need for funds for water supply projects, drugs, anaesthesia and sterilization supplies, etc. Hospital bed utilization rates had decreased, as well as those of surgical operations and health laboratories. He thanked WHO for its support, although it was insufficient for meeting even the urgent needs of his country. There were also difficulties hampering the development of medical education which needed urgent attention.

The experience of Bahrain related to the Prototype Action-Oriented School Health Curriculum for Primary Schools was presented. This approach had been implemented gradually, based on materials prepared by WHO, and now was being applied in all primary schools. The implementation was being evaluated by means of a questionnaire and in the light of evaluation

results activities were modified and adapted to relevant situations. Slides were also shown indicating programme activities such as health education, workshops attended by parents and activities carried out by schoolchildren themselves, aimed at the promotion of oral health, environmental health, etc.

The Chairman of the meeting congratulated the State of Bahrain on its successful programme, commended the efforts made by the Regional Director and the Regional Office to implement this action-oriented school health curriculum and expressed the hope that it would be implemented by all countries of the Region.

The Regional Director said that the experience of Bahrain was an example that was replicable in this important field. He said that diseases related to lifestyles could be part of our future. Since prevention was the best method to combat these diseases, there was no better way than preparing future generations and sensitizing them to the prevention of such diseases and the adoption of positive approaches, rather than relying totally on the Ministry of Health. The Ministry of Education was undertaking the role of health education for this sector of the population, emphasizing the important role of teachers. The participation of parents would hopefully lead to greater success of the programme, thus encouraging other countries of the Region. This was the first time the programme had been evaluated since its inception. It had shown good progress in Jordan even though no evaluation had yet been made. In Egypt the curriculum had been introduced in various school curricula. Important steps had been taken to implement the curriculum in Morocco. It had also been translated into Spanish, Chinese and French, and adopted by a number of Latin American countries. The Regional Director indicated that the Eastern Mediterranean Region had initiated the curriculum, and the countries of the Region should utilize it.

Statements by Representatives of Organizations

The President of the International Agency for the Prevention of Blindness (IAPB), H.R.H. Prince Abdul Aziz Bin Ahmed Bin Abdul Aziz Al-Saud, stated that many cases of blindness in the Eastern Mediterranean Region were preventable or treatable. He said that efforts were being made to mobilize resources from NGOs to help develop or strengthen activities in those countries in the Region that were severely suffering from blindness and eye diseases. He also called upon national leaders to have stronger commitment and political will to help in addressing the excessive burden caused by blindness. The Prince requested that the problem of blindness in the Region be placed on the agenda of the Regional Committee for 1995. He offered his personal support as well as that of the IAPB to all future EMRO efforts towards the prevention of blindness.

The Chairman of the Regional Committee said the Arab Gulf States had been a leader in the field of the rehabilitation of the blind; a rehabilitation centre had been established in Bahrain and important activities had been initiated in this field. He urged the countries of the Region to contribute to the development of the centre and supported the suggestion that prevention of blindness be included on the agenda of a forthcoming session of the Regional Committee.

The Representative of the Arab Union of the Manufacturers of Pharmaceuticals and Medical Appliances, Mr Bassam Abdel Rehim said that the Federation had held its first symposium on "Good Manufacturing Practices of Drugs in the Arab World", with a view to identifying standards and classification necessary for drug quality assurance. Issued both in

Arabic and English, *The Code on Good Manufacturing Practices of Drugs in the Arab World*, would be updated regularly to keep abreast of latest developments. The Federation had held several workshops on the application of these principles. Another workshop had been planned for October 1994 on "Auditing Good Manufacturing Practices of Drugs in the Arab World" on the same principles, and "The Arab Commission on Good Manufacturing Practices" would be formed for the same purpose.

The Representative of the Federation called on WHO and its Regional Office for the Eastern Mediterranean to support its efforts aimed at the application of the principles of good manufacturing practices. A symposium had also been held with the title "Towards the Establishment of a Common Arab Market", and the Arab Drug Formulary had been issued. Another two symposia had also been held, one on "The Development of Arab Manufacturing in the Arab World", and the other on "Transfer, Institutionalization and Development of Drug Manufacturing Technology". A unit for drug studies had also been established.

The Representative suggested the formation of a joint committee including representatives of the Council of the Arab Ministers of Health, the World Health Organization and the Federation itself, whose task would be to determine how to apply good manufacturing practices.

Mr Martin Weibel, President of the International Cystic Fibrosis (Mucoviscidosis) Association, said the Association had been affiliated with WHO since 1973. He was taking the opportunity of the Regional Committee Session to seek closer collaboration with the WHO Regional Office and its Member States to increase awareness of cystic fibrosis and to bring to the attention of national health authorities the problems associated with the disorder.

As a result of early recognition, diagnosis and treatment, the disease was no longer necessarily fatal. In those parts of the world where understanding of cystic fibrosis had developed, it was recognized that the disease had been underdiagnosed and treatment, if it existed, was incomplete. Lack of information on nutrition, basic care and physiotherapy often prevented effective and inexpensive treatment.

The Association, in collaboration with WHO, planned to develop further activities in the preparation and international dissemination of information, and relating to possible strategies for the control of the disease. It also planned to prepare educational material on the control of the disease, as well as guidelines for the development of national programmes for the control of cystic fibrosis.

Professor Iain Ledingham, speaking on behalf of the World Federation for Medical Education and the Association for Medical Education in the Eastern Mediterranean Region, endorsed the comments of the Regional Director in his Annual Report on the crucial importance of regional initiatives in medical education, research and development. He said that an Eastern Mediterranean regional meeting was planned, to be held in Al Ain, United Arab Emirates, from 29 January to 1 February 1995, and, in view of its importance, he solicited the support of all the countries in the Region.

Dr Ahmed Mandil, Representative of the International Epidemiological Association, conveyed the greetings of the Association and provided a resumé of the objectives and activities of the Association, which included dissemination of epidemiological information, enabling young epidemiologists to take part in local, regional and international conferences, and producing relevant publications. The President of the Association and the Director-General of WHO held a meeting early in 1994 and decided on steps to be taken to intensify cooperation

and collaboration between the two agencies. He called for closer association with EMRO in order to achieve the goal of Health for All.

Ambassador Gayama Pascal, the Representative of the Organization of African Unity (OAU) said that he thought it was necessary to strengthen cooperation between the Member States of the Region and the OAU. The heads of Member States of the OAU had adopted, at the Summit Meeting held in Tunis, Tunisia, in June 1994, a resolution to this effect. The meeting had also adopted a Declaration on AIDS and Children, sounding the alarm at the spread of the AIDS and its impact on the vulnerable category of children.

Dr Abdel Rahman Fakhro, the Representative of the Arab Medical Union, reviewed the many areas of cooperation between the Union and EMRO, including the Arabicization of medical studies and several scientific activities. Primary health care, the control of endemic diseases, continuing medical education and assessments of the demographic distribution of physicians and health institutions were among the priorities of the Arab Medical Union. The Union had established a scientific council, formed of all heads of specialized associations in the Arab world, as well as members of the scientific committee of the Arab Medical Union. The Union was deeply concerned about the deplorable health conditions of children in many parts of the Arab world owing to an embargo on some Arab countries. Thus, the Union had called for a lifting of the economic, food and drug embargo imposed on Iraq and the Libyan Arab Jamahiriya. It also called for the development of international legislation to ensure the protection of children in times of war and disaster.

3.2 Report of the Eighteenth Meeting of the Regional Consultative Committee

Agenda item 7, Document EM/RC41/5, Resolution EM/RC41/R.9

Dr M.H. Khayat, Director, Programme Management, presented the report. The Eighteenth meeting of the Regional Consultative Committee (RCC) had been held in the Regional Office on 28 and 29 August 1994. The RCC noted the follow-up actions taken in respect of the recommendations of its seventeenth meeting.

In its Eighteenth meeting the RCC discussed a number of topics, the first of which was home health care which was considered by the Committee to be a very important subject. It recommended that a status paper be prepared on the subject, emphasizing the particular assets of the Region, and that a consultation be organized to discuss the position paper and to determine steps to be taken to promote and maintain home health care within the sociocultural context of the Region.

The RCC then reviewed a paper on accident prevention. The Committee recalled the recommendations of previous meetings on the subject, considered that they were all still valid and recommended the establishment of national agencies made up of representatives from various sectors, emphasizing the leading role of the Ministry of Health in the National Programme on Accident Prevention, and the importance of collaboration between WHO and Member States in formulating good projects that could be supported by extrabudgetary funds.

The RCC then dealt with the subject of health and the environment and felt that the Ministries of Health should play the leading role in national environment protection committees or agencies for the environment and present the impact of any environmental changes on health. It would be advantageous if the representatives of Ministries of Health could be the secretaries of such committees. The Committee recommended that Member States take action to develop a coordinated intersectoral national plan of action on health and

the environment as per Agenda 21 of UNCED. It also recommended that EMRO should establish a "Health and Environment Regional Advisory Group" to follow up the plans of action and to strengthen collaboration with the United Nations and external support agencies.

The RCC then reviewed a follow-up on the International Conference on Nutrition, and recommended that WHO should increase its advocacy efforts, especially with regard to the effect of malnutrition and micronutrient deficiency on cognitive function, and that Ministries of Health take a leading role in nutrition as this ministry is the health conscience of the nation.

It is also recommended that the Regional Office should emphasize the importance of a nutrition component in all health programmes carried out in the Region and should assist Ministries of Health in identifying cost-effective interventions, especially in the area of micronutrient deficiencies, building on the experience gained in the control of iodine deficiency disorders.

The Committee then reviewed a progress report on cost-sharing in health systems, and recommended that:

- 1) EMRO should develop an appropriate plan of action for future activities, especially advocacy of the principles of health economics among Member States;
- 2) Further in-depth studies should be conducted on various cost-sharing systems under different situations in the Region;
- 3) The Regional Office should consider establishing appropriate support for the regional programme on health economics.

The RCC also reviewed another progress report on the use of traditional medicine in health care systems. Discussions emphasized that it was important to promote scientific research in that area and that there was a need to develop national legislation to ensure the safety, efficacy and quality of herbal remedies. It was also important to include information on useful herbal remedies in medical and pharmacy school curricula.

The RCC then reviewed the subject of extrabudgetary resources and recommended that EMR Member States, through members of the Executive Board and their delegates to the World Health Assembly, should make known the programme needs of the EMR countries to EM regional-based sources of funding, should promote the needs of the Region in relation to the global extrabudgetary-funded programmes, and should promote decentralization of Geneva-based special global programmes to those regions which were most affected by the activities of these programmes, and which had lower operating costs.

The RCC then dealt with the redistribution of partial reinstatement of programme budget implementation reduction. The Committee was informed by the Director, Administration and Finance (DAF), that a programme budget implementation reduction for 1994-1995 had become necessary because of an anticipated shortfall in the receipt of assessed contributions. This reduction amounted to US\$3 640 0900, of which US\$952 000 had been recently restored. DAF requested the Committee to indicate principles that could guide the allocation of the restored funds.

The Committee considered that to return the funds on a direct *pro rata* basis to each country would result in only relatively small additions to programmes which had already been readjusted and therefore it did not support this approach. Similarly, constitution of a

relief fund or other special funds was not considered practical because the funds must be used within the current biennium.

On the other hand, the Committee felt that the sum was large enough to promote a limited number of priority actions thus concentrating its impact. The Committee preferred that these actions be identified by the Regional Office.

Therefore, the RCC recommended that the restored amount should be maintained as a lump sum in the Regional Director's Development Fund for use in addressing emerging priorities.

The ninth and last subject reviewed by the RCC was the technical subjects for consideration by the Regional Consultative Committee in 1996-1997 and beyond, and the Regional Committee in the coming years. The Committee recommended a number of subjects, leaving to the Regional Office the responsibility of organizing their schedules.

Discussion

The Representative of Qatar had enquired about the activities to be funded from the restored amount of US\$952 000.

The Regional Director said that the Regional Consultative Committee considered that to return the amount on a pro rata basis to each country would result in only relatively small additions to programmes which had already been readjusted, and it therefore suggested that the amount be merged with the Regional Director's Development Fund for use for activities previously prioritized, including the emerging ones. Any country could propose a programme for funding, within the set priorities, and the Regional Office would abide by the said priorities.

4. BUDGETARY AND PROGRAMME MATTERS

4.1 Proposed Programme Budget for the Eastern Mediterranean for the Financial Period 1996-1997

Agenda Item 5, Document EM/RC41/3, Resolution EM/RC41/R.4

Mr R. Spina Helmholtz, Director, Division of Administration and Finance (DAF), introduced the Proposed Programme Budget for the Financial Period 1996-1997.

He indicated that it had been prepared in full collaboration with members and in accordance with the Regional Programme Budget Policy and the Ninth General Programme of Work covering the period 1996-2001. The Ninth General Programme of Work had established four new main policy orientations, namely:

- integrating health and human development in public policies;
- ensuring equitable access to health services;
- promoting and protecting health;
- preventing and controlling specific health problems.

These were reflected in the four main appropriation sections of the Budget.

The format of the budget document was intended to be more user-friendly, showing strategy and financial priorities, realistic and measurable targets, and regular evaluation of progress towards those targets, in accordance with a resolution of the Forty-sixth World Health Assembly (WHA46.35).

Mr Helmholtz explained that, while programme activities for 1996-1997 had been consolidated in accordance with the new less rigid Classified List of Programmes, the List had continued to be revised and, after the finalization of the document as presented to the Regional Committee, it had been modified once again. The final version for 1996-1997 would be used by headquarters when consolidating all regional inputs to the Organization's budget; thus, there would be a change in the presentation at that time.

He described the format of the document, emphasizing that the country programme statements reflected each current national health development situation, with an overview of programmes being implemented by the countries in collaboration with WHO or other agencies and organizations for which relevant collaborative activities had been proposed for 1996-1997. Outcomes expected for 1996-1997 had been defined, as far as possible, in measurable terms.

Mr Helmholtz, in analysing the trend of the distribution of extrabudgetary resources between Headquarters and the regions and among regions, demonstrated that, while overall extrabudgetary resources had almost doubled, the Eastern Mediterranean Region received a lesser amount in 1992-1993, as compared with six years earlier. Decreased funding from United Nations agencies as well as from voluntary funds led to this decline. Although the amounts now projected for 1996-1997 were expected to increase, the downward trend in extrabudgetary resources for the Region was apparent and was likely to accelerate if the funds for the Global Programme on AIDS were channelled to the newly proposed joint United Nations programme for AIDS.

A review of the WHO Regular Budget allocations reflected 35% for Headquarters, and 65% for all regions taken together, reflecting a slight decrease in the regional share compared with earlier years. The EMR receives approximately 10% of the total WHO Regular Budget.

The amounts withheld in November 1993 from provisional country planning figures for 1996-1997 had been fully restored and were included in the figures for each Member State and in the programme totals. The restored amounts would be allocated to the following four priority themes as proposed by the Director-General:

- human health in a changing environment;
- proper food and nutrition;
- integrated disease control as part of overall health care and human development;
- dissemination of information for advocacy, and for educational, managerial and scientific purposes.

Owing to time constraints, they had been included under the programme for Organization and Management of Health Systems Based on PHC, but could later be reprogrammed, keeping the above priorities in mind.

There was no real increase for 1996-1997, and Mr Helmholtz emphasized that allowable cost increases had not yet been decided. The proposed cost increases would be reviewed by the Executive Board in January 1995 and decided by the Health Assembly in May 1995. The figures before the Regional Committee for 1996-1997, therefore, allowed for no cost increases when compared with the preceding biennium. He also noted that 64% of all resources of the Regional Budget were devoted to country programmes.

The distribution of total regular budget and extrabudgetary funds, by appropriation section, allocated the largest share for Health Systems Development, with smaller, but approximately equal shares for:

- health-for-all policy development;
- prevention and control of disease and disability;
- protection and promotion of health.

Direction, Coordination and Management, and Programme Support were allocated the lowest shares, the latter representing 8% of total programme funds.

Mr Helmholtz stated that some technical programmes definitely stood out as receiving more funding than others; and with all the constraints, funding shifts among programmes for 1996-1997 had been made to reflect changing priorities.

Major increases or decreases in funding for 1996-1997, as compared with 1994-1995, were also described by programme. Programmes for noncommunicable diseases, tropical disease control and research, essential drugs, vaccines and other supplies and other communicable diseases including zoonoses had received increased budgets.

Figures for the Global Programme on AIDS had been omitted not because there would be no programme, but because the channels for its funding were not known with certainty at the present time.

The details for implementation of the present proposals would be worked out jointly with Member States within the context of the joint government/WHO programme review missions to be completed in 1995. Also, the Director-General would reserve his final decision

concerning the overall level of the 1996-1997 budget, pending his receipt of the views of all the Regional Committees.

Mr Helmholz referred to resolution EM/RC31A/R.8, "Voluntary Fund for Health Promotion - Special Account for Miscellaneous Designated Contributions (Health for All by the Year 2000 - Eastern Mediterranean Region)". The balance in the Fund, to date, amounted to US\$25 466 — no change from the balance reported in 1992. A full accounting of the Fund is in the Financial Report and Audited Financial Statements of the Organization. He proposed that the Regional Committee might agree that the Financial Report of the Organization constitute an adequate reporting on this Fund.

In conclusion, Mr Helmholz requested the Committee to review the regional Proposed Programme Budget and, if it agreed with the proposals, request the Regional Director, through an appropriate resolution, to forward it to the Director-General for its inclusion in the Proposed Programme Budget for presentation to the Executive Board in January 1995, and to the Forty-eighth World Health Assembly in May of the same year.

Discussion

The Regional Director took the floor indicating that the lack of the Region's extrabudgetary funds was clear. He recalled a resolution made by the Regional Committee two years ago requesting an increase in the Region's share in the Organization's Budget and asked the Executive Board members nominated by countries of the Region and also representatives to the World Health Assembly to raise this point, and to request the World Health Assembly to pass a resolution increasing the aforesaid share. Some Headquarters activities could also be carried out within the regions themselves, thus decreasing their implementation costs.

The Regional Director drew attention to the fact that most of the balance in the regional Health for All (HFA) Voluntary Fund had been donated by Pakistan and Saudi Arabia; he urged all countries of the Region to expedite their contribution to this fund.

Dr Gezairy finally proposed that, to facilitate the management of both the offices of WHO Representatives and the country programmes, the cost of these offices be separated from country allocations.

The Representative of Qatar said that the Administration, Budget and Finance Committee of the Executive Board would soon be convened and would hopefully discuss the subject of increasing the regions' share in the Organization's budget.

The Representative of Pakistan thanked WHO for its continued support. He particularly mentioned the success achieved by the National Immunization Days in increasing immunization coverage in Pakistan. Pakistan had to reorganize itself in regard to immunization. He noted that although in the proposed budget there was support for primary health care, there was no specific allocation for immunization, prevention of diarrhoeal diseases or ARI. He hoped that the budget could be reconsidered in view of his remarks concerning these areas.

The Representative of Sudan suggested that WRs' offices be left within the country allocations as the country could reduce the cost of these offices by providing accommodation, etc.

The Representative of Cyprus expressed the appreciation of his country for the continued support of WHO. There was evidence in this budget of great need as well as restricted funds. He was pleased to note that WHO was intending to concentrate on a smaller number of

programmes which it would develop more fully and finance more intensely. HFA Strategy would thus lead to improved quality of health care through better organization and management. He presented details of the Cyprus programme priorities as currently planned and requested that funds be allocated for research on childhood atherosclerosis.

The Representative of Bahrain commended the way the Proposed Programme Budget had been prepared and suggested that the Regional Office provide each country periodically with reports on country allocations, actual expenditures and the remaining balances.

The Regional Director indicated that there seemed to be a lack of allocations for programmes on immunization, acute respiratory infections and diarrhoeal disease control, but these programmes were implemented under the umbrella of primary health care, and could thus be funded within this framework without such support being made clear in the budget.

Concerning the cost of WRs' Offices, the Regional Director said that separating WR's allocations from country programmes would not keep from adding any savings achieved.

Dr Gezairy also indicated that Cyprus allocated a large part of its country allocations for a limited number of programmes and projects, and that he supported such a policy which would hopefully be adopted by other countries. The Regional Office regularly provided countries with computer printouts indicating exact budget figures for each country.

4.2 WHO Response to Global Change

Agenda item 11, Document EM/RC41/9, Resolution EM/RC41/R.15

Dr A.A. Saleh, (EDP) and Acting Regional Adviser, WHO Programme Development, introduced the topic.

He referred to the resolution of the Fortieth Session of the Regional Committee requesting the Regional Director (a) to forward its views on the report to the Executive Board; (b) to seek the views of the Regional Consultative Committee on the report; and (c) to report to the Regional Committee at its Forty-first Session on WHO Response to Global Change. He summarized activities undertaken by WHO in this respect.

The Regional Director presented the views of the Regional Committee to the Executive Board and the Global Policy Council (GPC).

The Director-General presented a number of reports to the ninety-third session of the Executive Board: (EB93.R13, EB93/11, EB93/11 Add. 1-10 and EB93/12) on the implementation of the recommendations of the Executive Board Working Group (EBWG).

The Director-General also presented to the Forty-seventh World Health Assembly (1994) three progress reports on action taken to implement the recommendations of the EBWG. Following discussions of these reports, the Forty-seventh World Health Assembly adopted the following three resolutions: WHA47.6, WHA47.7, WHA47.14. These resolutions were interrelated and covered the establishment of the Programme Development Committee and the Administration, Budget and Finance Committee, and procedural matters relating to Health Assembly resolutions.

As a follow-up to one of the recommendations of the EBWG during its ninety-third session in January 1994, the Executive Board divided itself into three subgroups. These undertook in-depth reviews of the several technical programmes. Following this successful experience, the Board decided to follow the same procedure during its ninety-fifth session.

The Director-General, in August 1993, decided to establish mechanisms linking programme management at headquarters with that in the regions, namely the Management Development Committee (MDC) and the Global Policy Council (GPC). The GPC, in turn, established six time-limited "development teams", which would cease to exist upon completion of their mandate; these teams, multidisciplinary groups of WHO staff, were to study developing policy concepts, elements, and management tools to implement rapidly and effectively the various recommendations of the EBWG within the context of the WHO managerial process.

The Regional Director had set up six regional core groups to prepare EMR's input to the various reports expected to emanate from the activities of the development teams; these groups were holding a series of meetings for the purpose.

Dr Saleh briefly reviewed the work of the six development teams, these being:

- WHO Policy and Mission;
- WHO Programme Development and Management;
- Management of WHO Information Systems;
- WHO's Information and Public Relations Policy;
- Role of Country Offices;
- WHO's Personnel Policy.

The WHO activities in response to the recommendations of the EBWG were presented to the eighteenth meeting of the Regional Consultative Committee, and were also discussed during the eleventh meeting of the Regional Director with WHO Representatives and Regional Office Staff.

The following recommendations were made:

- The regional development teams should try to take the greatest advantage of the ongoing exercise. Emphasis should be placed on analysis of the country and regional situation. The input to the global document should be based on country and regional needs.
- WHO should consider developing an efficient network of collaborating centres of excellence providing up-to-date technical and professional support through financing floating posts, hence economizing on the number of headquarters staff.
- WHO should consider moving some special WHO programmes (CDD, DAP, etc.) to the regions, as this would have a positive technical as well as financial impact.

Several activities were undertaken to implement the recommendations of the EBWG. It was important, however, to ensure that the documents that would result from these activities were user-friendly and easily adaptable to regional and country situations.

Discussion

The Representative of Qatar enquired about the formation of the teams mentioned in the report, and whether Member States were represented on the teams.

The Representative from Pakistan suggested strengthening the offices of WHO Representatives and decentralization of authority to overcome the present delays.

The Representative of Morocco requested that the regional offices be entrusted with a role in the activities related to the Organization's response to global change.

In replying to the above discussion, the Regional Director indicated that the said teams were internal bodies formed by the Director-General at WHO Headquarters and that regions had been invited to take part in their activities. EMRO had sought to make use of the expertise of different persons working in the Regional Office and country offices and convey their suggestions to teams formed throughout WHO. Examples were: transfer of some of the current activities of Headquarters to the regions and not necessarily to the regional offices, e.g. the HQ diarrhoeal disease control programme could be transferred to one of the countries suffering from an acute diarrhoeal disease problem. Considerable savings resulting therefrom could be used in supporting national programmes.

The Regional Director indicated that Headquarters had previously requested that the regional committees consider their methods of work. He enquired whether the members of the Committee saw a reason for changing the Committee's method of work, including the election of the Regional Director and the Director-General and asked them to submit whatever suggestions they had to this effect.

The Chairman of the meeting suggested that the Committee adopt a resolution reaffirming the one taken the year before, recommending continuation of the present method of work, with the regional offices being entrusted with a major role since they were in a good position to understand regional needs.

5. TECHNICAL MATTERS

5.1 Technical Paper: Sustainability of National Immunization Levels

Agenda item 9(a), Document EM/RC41/6, Resolution EM/RC41/R.13

Dr M.H. Wahdan, Director, Integrated Disease Control, introduced the subject. Most countries in the Eastern Mediterranean Region have made remarkable progress during the 1980s and early 1990s towards achieving EPI targets of high immunization coverage levels and disease control and eradication. However, during 1992-1993 some countries had been unable to sustain these achievements, or to improve upon them. Indeed some Member States had experienced an alarming decrease in coverage, resulting in outbreaks of vaccine-preventable diseases. Failure to stop this decline, or move beyond past achievements, seriously jeopardized achieving the targets for EPI in the 1990s.

The factors related to the sustainability of EPI were multifaceted, and varied from country to country. They included factors that were managerial, technical, political and financial in nature. In addition, attempts to restrict EPI services to the PHC system could not meet EPI needs in countries where the PHC infrastructure was not sufficiently developed to provide immunization services effectively.

In some countries, managerial problems had arisen owing to complacency, rapid turnover of staff, a decrease in the number of immunization sites, and diminished social mobilization efforts. Certain countries had faced critical shortages of EPI vaccines due to inaccurate forecasting of needs, erratic distribution systems, or difficulties in procurement. Natural disasters and civil unrest in some countries had significantly restricted EPI activities. Corrective actions included reducing missed opportunities and dropouts; appropriate integration of EPI into PHC; maintaining outreach and mobile activities where needed; increasing social mobilization to raise consumer demand and participation; and ensuring an uninterrupted supply and distribution of EPI vaccines.

Inadequate technical capabilities were due to a shortage of trained manpower resulting from frequent turnover and inadequate trainees, necessitating continuous training, both inservice and preservice, in various aspects of immunization and logistics.

Obtaining political support and commitment to EPI had to be maintained. Key decision-makers had, therefore, to be convinced and continually reminded that immunization was one of the most cost-effective health interventions that had to be continuously maintained. In those countries that were affected by civil strife, innovative strategies, such as "days of tranquillity", had to be implemented.

In many countries, immunization programmes had been heavily dependent on donors, without definitive plans for progressive self-sufficiency. This meant that when external resources contracted, coverage declined, resulting in increased disease incidence. It was essential that an increasing share of the funding of EPI was absorbed by national budgets. In low-income countries, external assistance would be needed for several more years. However, the duration of external assistance and the phasing-out period had to be carefully planned to ensure the long-term continuation of the programme.

Discussion

The Representative of Saudi Arabia emphasized the importance of strengthening epidemiological surveillance with a view to facilitating the identification of all nonimmunized children, as well as ensuring coverage for all eligible categories.

The Representative of the Islamic Republic of Iran said that a preliminary evaluation, carried out prior to the beginning of the Expanded Programme on Immunization, by a joint national and international team in June 1984, showed polio coverage of 34%, BCG 10%, measles 38% and TT2 for pregnant women 4%. Simultaneous to the commencement of the EPI had been the development of the primary health care system through health houses, and rural and urban health services. The situation, however, had improved considerably with extensive health education and the introduction of a policy to open one vial of vaccine for even one person; the present coverage was estimated at 95% for each of the six antigens in children under one year of age.

The surveillance system for notifiable diseases, including EPI diseases, had been strengthened and outbreak response was being carried out whenever cases occurred.

The country was in the control phase as regards measles and in the elimination phase as regards neonatal tetanus but, despite a high level of immunization coverage, polio cases continued to occur. Therefore, two rounds of national immunization days (NIDs) were conducted in March and April 1993, and it was planned to have similar NIDs in 1995 as well. It was suggested that regional immunization days be held through coordination of all countries in the Region, WHO, UNICEF and other agencies.

The country was self-sufficient with regard to production of BCG and DT vaccines. There was spare capacity to produce antigens for other countries, if necessary, with support from WHO.

The Representative from Pakistan had stated that there were additional factors in sustaining immunization levels, among which were huge financial outlays which were beyond national capabilities, coupled with "donor fatigue". The problems that limited progress in developing countries were mainly financial and managerial, but definitely not technical.

The steep increase in cost of vaccines and logistics added to the constraints in sustaining the levels and meeting the goals. He considered that the international community should come forward to meet some of the needs of developing countries and contribute to technology transfer and promotion of vaccine production.

He felt that upgrading and better utilization of the health infrastructure and community participation could ameliorate the situation, though community involvement had been sometimes painful. The slow development of primary health care services militated against sustainability of the programme in the long run. He hoped that these additional factors would be taken into consideration in the formulation of recommendations.

The Representative of Tunisia noted that costs of vaccines were on the increase continuously, which affected the immunization coverage rate. Use of vaccines should be rationalized and immunization activities intensified in areas where coverage was low, in accordance with set targets.

The Representative of the Libyan Arab Jamahiriya indicated that immunization against hepatitis B had been introduced in immunization schedules and that there was a joint

programme among the Maghreb countries within which immunization activities were coordinated. A national immunization week was held annually.

The Representative of Egypt enquired whether only one dose of measles vaccine was sufficient to achieve the target of decreasing measles cases.

The Representative of Oman emphasized the need to limit missed immunization opportunities and give due attention to vaccine quality.

The Representative of Kuwait enquired about the introduction of influenza vaccine among the EPI vaccines.

The Representative of Afghanistan said that, in his country, immunization as part of primary health care did not receive the attention it deserved, the levels were unacceptably low, and the EPI-target diseases were rampant, particularly in the vulnerable populations. The Ministry of Public Health was responsible for the delivery of immunization services, in collaboration with WHO, UNICEF and other agencies; nongovernmental organizations were also involved.

A new infrastructure was being adopted and it was hoped that this new initiative would enhance the efficiency of EPI particularly.

The Representative of Morocco urged attention to outreach areas which received attention during national immunization days only.

The Representative of the Republic of Yemen emphasized the importance of coordination between countries of the Region in the different areas related to the immunization programme, including training and experience sharing.

The Representative of Sudan said that a target had been set to achieve 70% coverage by the end of the current year. A campaign to immunize 3 million children against polio had been launched and another campaign would be launched soon. A national plan for neonatal tetanus eradication had been developed, and a polio eradication plan was being considered.

Commenting on the discussion, Dr Wahdan said that the Regional Director had formed a technical group to be convened early next year to study the subject of whether the use of only one dose of measles vaccine was enough to achieve the target of decreasing measles rates. Additional vaccines could be added to EPI vaccines such as hepatitis B vaccine. In light of the epidemiological situation new vaccines such as *H. influenza* can be introduced in the immunization schedules. As regards coordination, Dr Wahdan indicated that WHO attached particular importance to this, and that several activities were carried out in that respect, including holding an annual meeting for national EPI managers where the opportunity was available to coordinate between national immunization programmes.

A meeting had been held for the vaccine producing countries, and missions had been sent to those countries that had made recommendations for the promotion of vaccine quality. Both WHO and UNICEF were giving attention to vaccine quality assurance and self-sufficiency in vaccine production.

5.2 Technical Paper: Changing Patterns of Diseases and Their Impact on WHO Collaborative Programmes

Agenda item 9(b), Document EM/RC41/7, Resolution EM/RC41/R.7

Dr M.H. Wahdan, Director, Integrated Disease Control, introduced the topic.

He said that there was a general shift from acute infections and deficiency diseases to chronic noncommunicable diseases. This transition was a dynamic and complex one, and was not unidirectional, because it was possible that sometimes, even a reversal of the trend might occur.

The mechanisms involved in the transition were described in detail. They included (a) demographic changes, usually in the form of reduced mortality, especially in infants and young children, followed, after some years, by reduced fertility; and (b) changes in biological, environmental, social, cultural and behavioural factors and in the practice of modern medicine. The biological factors included alterations in the antigenic identity of microorganisms, such as the influenza virus and the cholera vibrio, and emergence of drug-resistant strains as in the case of cholera, tuberculosis and malaria. The environmental factors included exposure to environmental pollution as well as overcrowding. The social, cultural and behavioural factors included changes in social relationships that adversely affected community ties, e.g. in care of the elderly, changes in lifestyles and decreased concern about moral values, which lead to increased drinking, smoking and sexual promiscuity. The practice of modern medicine had also contributed to this transition — as a result of the discovery of antibiotics, insecticides, vaccines, improved or new technologies, diagnostic reagents, and increased manipulative procedures. Although these practices are useful in disease control, they have harmful side effects, especially contaminating the environment with the chemicals and radiation used.

This process of transition was very vulnerable and could be affected by several factors. The indicators for such transition included changes in mortality and morbidity and others, reflecting social and behavioural changes.

Dr Wahdan's presentation included a review of the response by national authorities to such changes. He emphasized that, in addition to providing services that met health needs, national authorities had to try to influence the transition positively by addressing the determining factors.

The response of WHO had also been changing, according to changing patterns. During the first two decades of WHO's existence, support had mainly been provided for the control of infectious diseases, through more or less vertical programmes, with some evident successes. During the 1970s and early 1980s, the emphasis shifted to the development of national health care systems able to cope with the need to meet the goal of health for all. Then came the period of the late 1980s and 1990s, when emphasis was also laid on chronic noncommunicable diseases. He concluded that communicable diseases continued to be of great public health importance throughout the Eastern Mediterranean Region.

Discussion

The Representative of Saudi Arabia agreed with the recommendations included in the report presented by Dr Wahdan, and added that his country was aware that the development of health services and technologies had led to a decrease in the rate of occurrence of certain diseases and the appearance of other diseases. This was due to changes in nutritional behaviour

and a more sedentary lifestyle. Accordingly, Saudi Arabia proposed to develop new programmes to address those diseases within the concept of PHC and to educate, sensitize and motivate people to change unhealthy lifestyles.

The Representative of Djibouti pointed out that his country suffered from many health problems due to movements of populations. This had caused a resurgence in some diseases and their establishment in the country, such as tuberculosis which had spread considerably in the past five years. Furthermore, diseases such as HIV/AIDS had been transmitted to the population.

The Representative of the Islamic Republic of Iran noted that disease patterns were similar in many countries. In 1990, cancer was the third leading cause of death in his country. A survey had been conducted in 1990 to ascertain the prevalence of diseases and the results of the survey would be used in planning services. The results of the survey also showed that the prevalence reached 3.1–3.9 in the 40–69 age group and that accidents were the second most important cause of death, followed by cardiovascular diseases. A number of projects were implemented on the control of noncommunicable diseases.

The Representative of Afghanistan stated that several years of civil war in his country had had a considerable impact on the patterns of disease. Mass movements of people due to war had resulted in a several-fold increase in the prevalence of diseases, such as malaria, tuberculosis, and malnutrition over that of pre-war levels. In fact, Afghanistan was witnessing an epidemiological reversal in the pattern of diseases. To address this situation, the Ministry of Public Health had decentralized the health services and had made efforts to utilize national and international resources more efficiently.

The Representative of Tunisia said that within the framework of the changing pattern of diseases and the increasing knowledge of the factors which affected their epidemiological situations, the health sector was expected to change its emphasis. He suggested that a paragraph be added to the resolution of the Regional Committee urging the health sector to play a more positive role.

The Representative of Kuwait indicated that mental diseases had increased among his countrymen as a result of the torture inflicted upon them during the occupation of Kuwait.

The Representative of Bahrain focused on the therapeutic changes which he said corresponded to the changing patterns of diseases. As an example, he said that priority within primary health care was given to immunization and control of epidemiological and environmental diseases. In addition, attention was to be given to patients suffering from cardiovascular diseases, cancers and kidney problems. Such programmes, implemented by countries, needed to be supported. In addition the development of new programmes for cardiovascular surgeries and transplants was to be encouraged.

5.3 Third Report on Monitoring Progress in the Implementation of Health-for-All Strategies

Agenda item 10, Document EM/RC41/8, Resolution EM/RC41/R.12

Mr M. Ouakrim, Regional Adviser, Health Situation and Trend Assessment, presented the topic. Despite favourable political developments regarding the restoration of peace in Lebanon and the Israeli-Palestinian agreement, civil strife and wars in Afghanistan and Somalia had caused great loss in human lives, injuries, displacement of populations and the disruption of health delivery systems.

Even if the GNP per capita had increased slightly as compared with the findings of the second evaluation exercise (1990), the difficult economic conditions, caused by inflation and deterioration in terms of trade, were putting serious strains on resources devoted to health at a time of increasing demands and expectations. As a result, the limited available data had shown a downward trend in per capita health expenditure in both nominal and real terms. Most governments were giving a low profile to health in their investment budgets. Allocation of resources within Ministry of Health budgets did not always benefit primary health care services.

The problems of availability of human resources for health varied between and within countries and between categories of health personnel. It appeared however, that health services were expanding faster than the increasing numbers of trained nationals. Physical accessibility to health services was improving, although it remained unbalanced within countries in favour of urban areas. In some countries incentives were provided to improve equitable access to health care.

Population growth was still high owing to a high level of fertility and a continuing decrease in mortality rates. The regional population was young, with 44% below the age of 15, although some countries were slowly going through a demographic transition. The demographic structure put more pressure on the health system owing to specific health needs (i.e. MCH services). The growth of the population, which exceeded that of the economy had led to an increase in unemployment, and particularly in underemployment, with a negative impact on health status.

Health was considered a human right and a social goal; the goal of Health for All (HFA) continued to receive endorsement at the highest levels and many countries had updated their policies and strategies in line with HFA goals.

Member States were paying great attention to the development of health systems based on primary health care, with expansion of services to rural and remote areas, decentralization through well-functioning district health systems, proper referral systems and improvement of the managerial process for national health development.

Innovative approaches to intersectoral collaboration and community participation and empowerment were being initiated in many countries, using the Basic Minimum Needs approach and other innovative means. As a consequence, access to safe water and appropriate sanitation was increasing, although coverage of the rural population with adequate sanitation still needed to be improved.

The development of health systems based on primary health care had led to improvement in many areas marked by indicators. More attention was needed regarding coverage by some health services. MCH services, including prenatal and postnatal care; assisted deliveries and immunization programmes, needed more support.

As the impact of health services on "complete physical, mental and social well being" was difficult to measure, negative measures of mortality and morbidity were being used as proxy indicators.

Infant mortality was decreasing even though some countries were still far from the regional target. The number of countries which had already reached their regional target had doubled between 1985 and 1993. The slight increase from the second evaluation report was due to higher revised estimates from some countries and to a sharp increase in infant

mortality in Iraq as a consequence of the embargo, as well as to the conflict situation in some less developed countries in the Region.

The maternal mortality rate had changed slightly since the first evaluation in 1984. Figures relating to maternal mortality were likely to be underestimated, based on limited hospital data or on defective vital registration. Meanwhile, the majority of the women who died lived in poor areas, were poorly educated if at all, and had had repeated pregnancies at short intervals.

Reliable data relating to the causes of mortality were scarce and were often limited to hospital deaths, thus limiting international comparisons. Acute respiratory infections and diarrhoeal diseases were still prominent causes of mortality. Deaths resulting from EPI-target diseases (except tuberculosis) were decreasing, while deaths due to cardiovascular diseases, accidents (particularly road traffic accidents), neoplasms and other respiratory and urogenital diseases were on the increase. This situation had emphasized the epidemiologic transition being witnessed in many countries of the Region.

Trends in morbidity were rather difficult to assess for use in international comparisons. Data in national reports were quite heterogeneous and based, in most cases, on outpatient and inpatient medical records, and did not accurately reflect morbidity.

Discussion

The Representative of Iraq said that the health service coverage, especially primary health care with all its elements, had been radically reduced due to the embargo imposed on his country. Examples he presented were the problems hindering efforts to provide safe drinking water because the production and importation of chlorine had been banned; coverage with vaccines such as DPT and polio were also declining.

The Representative of Sudan indicated that with the decentralization to the state system from a federal one, the resources had become available for the health sector from three sources: the Federal Budget, the State Budget, being separated from the Federal Budget, and the Local Council Budget. He referred to the declining external support for the Expanded Programme on Immunization since 1989, as well as for malaria control activities. He thus urged the Regional Office to extend assistance to his country to face such a difficult situation.

The Representative of Pakistan pointed out that health was an indicator of the social and economic status of a country. He also said that priorities of individual countries had a role to play. The Representative requested that WHO consider the economic status of a country when allocating funds.

He continued that recently the Government of Pakistan had realized that health was a most important consideration and that it was simply more cost-effective to have healthy people. There was also the realization that Pakistan must control the growth of its population, which was clearly demonstrated during the recent International Conference on Population and Development in Cairo, and the courageous pledge of Prime Minister Benazir Bhutto.

To fulfill this pledge, the Government of Pakistan had recently increased the health budget by 170%; the bulk of these funds were directed towards family planning and family health care. Specifically, such programmes would be aimed at rural areas, with emphasis on the community. The link between the government-delivered health system and the community would take the form of female health workers, hired and trained by the

Government whose main role was to increase the participation of the population in family planning.

The Representative of the Islamic Republic of Iran emphasized the importance of "all" in health for all. He said that the third report on monitoring was meant to reflect the progress of the entire region and all countries should be enabled to reach their goal. He asked the countries to help each other, in the spirit of Islam. He added that EMRO was doing its best but the countries themselves needed to do more, coordinated by EMRO. Some countries needed help at that time, someday other countries would need help. He pointed out the reduction in budgets and requested the Regional Director to make the utmost effort in serious cooperation to help needy countries.

The Representative of Afghanistan said that his country was committed to Health for All, but due to many years of conflict, it could not promise full achievement by the year 2000. Recently, Afghanistan had adopted a new framework for basic primary health care services which was based on community involvement, the appropriate technology and intersectoral cooperation. He expressed the hope that this new action would accelerate progress towards achieving health for all.

The Representative of Cyprus stated that Health for All was the great dream of humanity and that health for all also meant natural life for all. It was an anomaly that the Region was struggling to achieve health for all while people were killing each other. He asked that the representatives of Member States act as one and help each other, as it was the formula for success.

The Representative of Morocco suggested that a recommendation be made on the need to rationalize the resources available for the health sector, recalling a previous resolution made by the World Health Assembly requesting that the health sector budget be increased. He also emphasized the importance of intersectoral coordination.

5.4 Diabetes Prevention and Control

Agenda item 12, Document EM/RC41/10, Resolution EM/RC41/R.6

The item was presented by Dr A. Alwan, Regional Adviser, Noncommunicable Diseases. Diabetes mellitus, a global health problem of considerable magnitude, was now emerging in the Eastern Mediterranean Region as a cause of major public health concern. Factors that contributed to the increasing prevalence of diabetes included improved survival and a longer life expectancy, changes in nutritional trends and dietary patterns associated with modernization, increasing prevalence of obesity and a tendency towards physical inactivity.

During the last decade, data on the epidemiology and clinical characteristics of the two types of diabetes, non-insulin-dependent diabetes mellitus (NIDDM) and insulin-dependent diabetes mellitus (IDDM), were available from Egypt, Iraq, Kuwait, Oman, Saudi Arabia, Sudan and Tunisia. The studies indicated that diabetes affected up to 10% of the population 20 years of age and above (in some communities), and this figure reached 20% if impaired glucose tolerance (IGT), a lesser degree of glucose intolerance, was also included. These figures were considerably higher than the prevalence reported in many developed countries and demonstrated the high susceptibility of populations in the Region to diabetes.

Both acute and long-term complications were commonly encountered. A substantial proportion of children with IDDM presented with ketoacidosis for both IDDM and NIDDM, and long-term complications, such as cardiovascular diseases, renal failure, retinopathy and

neuropathic involvement, were already major causes of morbidity, disability and premature death in the Region.

Despite the high prevalence of diabetes and its complications, essential health care requirements and facilities for self-care were inadequate in many countries, while in some, an alarming situation existed as to the health care status of people with diabetes, particularly those of the insulin-dependent type. People often had no access to even life-saving drugs, for example insulin. Facilities and experience in the management of long-term complications, such as vision-threatening retinopathy and renal failure, were not available in some places and grossly inadequate in others.

Given this situation and the changing demographic, nutritional and disease patterns in the Region, it seemed clear that the burden of diabetes and the predictably enormous cost of the disease could not be ignored.

Primary prevention of diabetes could be achieved by correction of obesity and increased physical activity and by promotion of health nutritional trends. For established cases, the objective was to prevent or reduce complications and disabilities caused by diabetes (secondary and tertiary prevention), by good management and by ensuring the availability of essential requirements for appropriate health care delivery to people with diabetes.

Discussion

The Representative of Bahrain said that 5-10% of the Region's population was suffering from diabetes. Due attention had to be given to the pre-diabetic stage, and studies had to be conducted on how to identify the persons in this stage. Diabetes should be viewed as one of the results of insulin resistance due to obesity and a sedentary life. Patients with high blood pressure were also prone to diabetes. Existing programmes had failed to reduce the risks of these diseases; costs were high and they were not cost-effective. Countries were invited to prepare national programmes for diabetes prevention and control, including health education and sensitization to the risks of diabetes. He requested that the relevant resolution urge Member States that had not yet done so to prepare their national programmes on diabetes prevention and control.

The Representative of Tunisia requested the Organization to publish relevant materials indicating the magnitude of the diabetes problem, giving due attention to primary prevention and coordination with other programmes such as maternal and child health, as well as to the care of diabetics in primary health care centres where they could be educated and provided with the necessary medicines at affordable prices. Furthermore, he said that health personnel should be trained on how to care for the diabetic.

The Representative of Morocco requested that social and cultural factors related to diabetes in the Region receive attention during the development of information and health education materials. He suggested that countries be encouraged to reduce duty on imported diabetes medication.

Professor Abdul Samad Shera, Secretary-General of the Diabetic Association of Pakistan, conveyed the greetings of the Secretary-General of the International Diabetic Federation. He complimented the Regional Office on its exemplary efforts in the promotion of diabetes prevention and control. He said that, in Pakistan, an estimated 12% of the population, in addition to the 30% mentioned by Dr Alwan, suffered from impaired glucose tolerance. He shared with some others the viewpoint that central obesity was being recognized as one of the

important factors in diabetes, in addition to insulin tolerance. With diabetes emerging as a major public health problem over the last two decades, he requested the Regional Committee to adopt a resolution urging Member States to take necessary measures to provide all those with diabetes with minimum standards of care and the immediate initiation of national plans of action.

Dr Alwan commented on the discussions, recognizing the importance of the preparation of national programmes for diabetes prevention and control, the primary prevention of diabetes and collaboration with other health programmes, both within the Ministries of Health and the Organization. The Regional Office had already adopted this approach noting that primary prevention had worked well in the field of cardiovascular diseases. EMRO had also held a Regional consultation the year before on the development of educational materials that would take into account various factors and conditions in the Region.

5.5 The Need for National Planning for Nursing and Midwifery in the Eastern Mediterranean Region

Agenda item 13, Document EM/RC41/11, Resolution EM/RC41/R.10

Dr E. Abou Youssef, Regional Adviser, Nursing and Paramedical Development, introduced the document.

Nursing and midwifery services were one of the main pillars of the health system of any country. Member States in the Eastern Mediterranean Region were confronted with various difficulties in meeting the demands of these services, both from qualitative and quantitative perspectives.

She added that countries of the Region face various difficulties in meeting requirements for those services, as a result of an increased demand on the one hand, and an inadequate supply of appropriately qualified nurses on the other. Increased demand for nursing services was the outcome of expanding health systems infrastructure, increased population, greater awareness of the public of the importance of health care, and the introduction of medical technology in service delivery. She pointed out that insufficient numbers of candidates applying to nursing schools, increased immigration of competent nurses, and high attrition of nurses, working particularly in hospitals and the public sector, contributed to the inadequate supply of nurses. That shortage was due to the fact that trained nurses were fewer than the nursing posts available and that few nursing posts were provided for in the approved government budgets.

The pressing need to provide care for both the sick and the healthy in the community was one of the major reasons that led to an influx of qualified and unqualified persons to work in the field of nursing. This led to the emergence of some 22 categories in nursing and midwifery throughout the Region, resulting in differing service types and performance levels which had a negative impact on planning, management and delivery of nursing services.

Analysis of the current situation of basic education in nursing revealed the existence of several levels which were not only different from one country to another, but also within the same country. This was due to the lack of educational criteria, which led to differences of educational programmes, low education standards, and consequently the incompetence of nurses. Basic education in nursing also suffered from several other defects, such as differences in admission requirements adopted by nursing schools and institutes, the irrelevance of nursing curricula to the needs of the countries of the Region, a shortage of nursing teachers, a lack of necessary educational materials in the majority of nursing schools and institutes, and poor field practice.

In view of the rapid and constant advances in various medical areas, and given the factors that negatively affected the basic education of nursing, efforts had to be made to provide opportunities for improving the efficiency of nursing personnel, thorough in-service training, continuing education programmes, specialized training or postgraduate studies. The majority of the countries in the Region have no programmes in the areas of specialized nursing, such as intensive care nursing, accident and emergency nursing, management of cancer patients, education of diabetics, infection control and care of the elderly. There are no systems for continuing education or in-service training for nursing personnel in a number of the countries of the Region. Efforts should be made to make available the education and training that would ensure the provision of fresh knowledge and improve efficiency, thus upgrading nursing and health services.

Dr Abou Youssef stated that opportunities for overseas training through fellowships were limited and that in 10 countries of the Region no nurse or midwife had obtained a WHO fellowship during the 1992-1993 biennium. The percentages of nurses who obtained WHO fellowships in 1992 and 1993 was 4.9% and 6.4% respectively.

Among the factors hindering nursing services, in addition to the poor clinical performance of nursing personnel, were inadequate resources, a lack of a system for evaluating nursing care and assessing and controlling service quality, as well as the undefined job description of the various categories of nursing personnel, poor supervision of nursing personnel, the inadequacy of nursing practice codes, and the lack of modern legislation regulating nursing practice, as well as of guidelines on nursing activities that nurses could use.

Dr Abou Youssef raised some major issues affecting nursing and midwifery development in the Region. These included the status and image of nursing as a profession, the limited opportunities available for specialized training in nursing, the changing scope of nursing practice and the lack of nursing leadership development.

She reviewed the activities recently carried out by the Regional Office to develop nursing at both regional and country levels.

Finally, Dr Abou Youssef pointed out that in view of the fact that nursing problems differed from one country in the Region to the other, it was not possible to find one solution for them all. It was therefore most important that the officials concerned in the Ministries of Health adopt a systematic approach in this regard. She emphasized the importance of formulating a national strategic plan for nursing and midwifery services that would address priority problems, with a view to enabling those services to contribute to national health strategies and to the efforts to achieve health for all through the primary health care approach.

After the presentation made by Dr Abou Youssef, Dr Friha Al Derazi, a member of the delegation of Bahrain, made a presentation on Bahrain's achievements in the field of nursing development, in the light of the Regional Strategic Plan on Nursing Development which had been formulated by the Regional Panel on Nursing in the Eastern Mediterranean Region. She indicated the process of reorientation of nursing curricula towards the concepts of primary health care, the problem solving approach, community-oriented activities and community participation.

Due attention was paid to legislation organizing the nursing profession, training and continuing education, control of nursing care quality, formulation of nursing policies,

development of nursing education, as well as encouraging national cadres to join the nursing profession.

Discussion

The Representative of Lebanon expressed satisfaction that the paper presented the experience of Bahrain in the field of nursing. He then reviewed the situation in his country stressing the lack of nursing personnel and its poor distribution. He added that it was necessary to establish collaborative programmes with the other Member States of the Region to promote this profession among males and females alike.

A delegate from the Islamic Republic of Iran commented that nursing education had to be considered within the social situation of the Eastern Mediterranean Region. Training of men was also necessary, as this was a career for both genders. There was also a need for reorientation of the profession towards community-based services. Particularly in the field of public health nursing, there was a lack of role models. Also, there was the need for an exchange programme between nursing and medical education for a more holistic approach to the profession; nursing should also be more community oriented. The nursing programme in the Islamic Republic of Iran, which was developed in 1989, placed equal importance on modern approaches in nursing education and health services. She also emphasized the need for reliable data to define more adequately the problem of nursing.

There was a great need for the exchange of information between countries of the Region and between other regions, as well as the need for more cooperation between nursing advisory committees.

The Representative of Jordan stated that it was very important to develop the nursing sector through continuous education, increasing capabilities and changing negative attitudes. He also mentioned that his country had suffered, until the beginning of the eighties, from a shortage in the number of nurses. The situation, however, had greatly improved after the establishment of several nursing faculties and institutes. At present, priority was being given to the improvement of the quality of nursing services, and not to the increase in the number of nurses.

The Representative of Afghanistan said that during the long war in Afghanistan, different nursing personnel were trained by various nongovernmental organizations without relating the training to the actual needs or basing them on existing health services, which had a negative impact on the performance of nursing personnel.

The Representative of Afghanistan asked the Regional Director to consider ways to encourage nongovernmental organizations to respect the guidelines and strategies adopted by the Advisory Panel on Nursing of the Eastern Mediterranean Region regarding the training of nurses. Nongovernmental organizations should not deliver just the health services they want. He also emphasized the importance of training health workers in accordance with the actual needs of the country.

The Representative of Egypt commended the report, referring to the usefulness of the recommendations included therein, for upgrading the level of the nursing profession. He noted that in Egypt girls practised nursing at a very young age, and that accordingly, they were unable to keep abreast of the developments in the field of medical technology. Consequently, technical nursing institutes and schools had been established which accepted students who had finished their secondary education. Egypt also encouraged male nursing services, he said, particularly in fields that necessitated physical strength.

The Representative of Qatar raised the subject of using foreign nurses in his country as well as other countries of the Region. He explained that this was not due to the small number of nurses or a lack of interest in the nursing profession, but to the small number of nursing cadres.

A member of the delegation of the United Arab Emirates shed light on the importance of supporting nursing leaders and providing them with authority as well as responsibility, thus enabling them to develop nursing services.

The Delegate from Oman agreed with what was said and emphasized the need for a strong political commitment. Health problems in the Eastern Mediterranean Region were so often preventable if we would only invest in nursing.

She said that Oman relied largely on the nursing regulations and registration of other countries and proposed that the Member States and other countries exchange information among themselves. She said that Oman relied to a great extent on a foreign workforce for its nursing needs but there was still a need for proper regulations.

The Representative of Sudan reviewed the situation of nursing in his country and mentioned that the problems faced there related to both the quantity and quality of nursing services. However, great efforts were being exerted to solve these problems: the national plan which had been developed provided for the establishment of several faculties and schools of nursing, the issuance of a resolution and law for the establishment of the Sudanese High Council for Nursing, and training grants and fellowships were being awarded to develop nursing capabilities. Attention was also being given to training male nurses.

The Representative of the Republic of Yemen raised the problem of the lack of interest among girls studying and practising nursing in his country. Accordingly, the country, although poor, had to rely on foreign nurses. He continued that the Ministry of Health was encouraging hospitals to establish schools for graduating nurses. He added that a project for the establishment of a central health institute has been initiated for the purpose of providing nursing services, and he requested the Regional Office to provide it with the necessary support. He also pointed out that the role played by donor organizations in that area was not very positive as they did not cooperate in any concerted way with the Ministry. He added that there should be a uniform job description for nurses in all countries of the Region.

The Representative of Cyprus said that currently there were more than 1600 nurses working in the public health services. The intake of students in the nursing school had also been increased: at present, there were 150 students in the third-year programme, 200 in the second-year and 200 in the first-year of studies.

Nursing studies were popular, judging from the fact that about 800 applications were received in the past year for the 200 positions available.

His Government had fulfilled the assurance given earlier of establishing the position of a Nursing Director in the Ministry of Health.

He associated himself with the sentiments expressed by the speakers from the Islamic Republic of Iran, Oman and the United Arab Emirates on the efforts of the Regional Office in improving the nursing services in the Region and assured WHO of the highest political commitment to this end.

5.6 Tuberculosis Control — Progress Report

Agenda Item 14, Document EM/RC41/12, Resolution EM/RC41/R.14.

Dr Z. Hallaj, Regional Adviser, Control of Communicable Diseases, presented the document. Over the last few years there had been an alarming global resurgence of tuberculosis (TB). This was due to a number of factors, including poor management of national tuberculosis control programmes (NTCP), the pandemic of HIV infection, widespread multidrug-resistant tuberculosis and social upheavals resulting from man-made and/or natural disasters. Countries in the Eastern Mediterranean Region had been affected, more or less, by all these factors, to varying degrees.

The tuberculosis situation in the individual Member States of the Region varied widely. In a few countries, the disease did not constitute a significant public health threat, while in most countries it was a major public health problem. In 1992, 213 551 new cases (all forms) were reported among the 411 million population in the Region, giving a regional annual rate of incidence of 50/100 000 population; the reported number of smear-positive cases was 75 956 or 20/100 000 population. This figure was far below the actual number of cases, in view of the fact that the expected number of smear-positive cases could reach 205 000, i.e. 50/100 000 population. Calculations based on these estimates indicated that over 800 000 cases needed health care in the Region.

The present situation represented an appreciable growth over what it was five years earlier, when a report had been presented to the Regional Committee (1989). This progression was particularly marked in increased reporting of cases, as well as in the improved proportion of detection and treatment of smear-positive cases. Also, an increasing number of countries had been reorienting their NTCPs on the basis of the new tuberculosis control policy.

However, various factors, alone or in combination, were impeding progress in tuberculosis control in some countries of the Region; these included, in particular: disrupted health care services due to man-made or natural disasters; lack of national commitment to effective control; a shortage of essential anti-tuberculosis drugs, scarce human resources trained in tuberculosis control; inadequate involvement of the private sector; and limited integration of tuberculosis control into primary health care services.

If these factors were addressed, the observed overall progressive trend of improvement of the tuberculosis situation in the Region could be promoted, and there would be a good chance that the disease in the Region could be brought under acceptable control within a reasonable period of time.

Discussion

The representative of Sudan explained that the high rate of prevalence of tuberculosis in the country was due to the fact that, geographically, Sudan was in the AIDS belt on the African continent, and there were movements of population from neighbouring countries due to civil strife. A project for the control of TB was planned that would rely mainly on short-term chemotherapy, as well as the detection of cases by health assistants. Sudan had also established a new department for the control of tuberculosis within the Ministry of Health, but had been hampered by the lack of drugs and personnel.

The Representative of the Islamic Republic of Iran said that the integration of the NTBP into the PHC system in his country had led to remarkable improvement in case detection and treatment supervision activities, particularly as regards recording and reporting

at district level. During the first year of the programme, monthly reports on TB were received from all districts of the country. The incidence rate was 33 cases per 100 000 (22% were smear positive); 61% were smear negative, 16% were extrapulmonary and 2% suffered relapses.

At present the major problems facing TB control were insufficient knowledge of treatment at local level, insufficient familiarity with the disease among physicians and a large number of external refugees in the country.

The Representative of Saudi Arabia pointed out that his country had started to implement the activities of the national programme for the control of tuberculosis, and it was expected that this programme would be applied in all parts of the Kingdom in the near future. He asked if treatment in case of infection coupled with HIV was different from treatment of cases not coupled with HIV infection.

The Delegate from Afghanistan presented the latest figures on tuberculosis in Afghanistan. A new pilot programme in selected centres was being carried out. There were 115 new cases per 100 000 annually. Of those treated, less than 30% were cured.

The Delegate of Pakistan emphasized the important role played by epidemiological studies, and encouraged countries to allocate funds specifically for this important aspect of tuberculosis control.

The Representative of Jordan endorsed the recommendations included in the report and referred to the pioneering experience of Jordan in the field of short-term chemotherapy. In addition, Jordan belonged to the low TB prevalence rate group of countries. Nevertheless cooperation between Jordan and WHO had not been satisfactory recently, and was restricted to the awarding of fellowships. He expressed the hope that cooperative activities between the two parties in the various fields would increase.

The Representative of Morocco pointed out that Table 4 on page 8 of the report indicated that the national programme for the control of tuberculosis in Morocco was not integrated into basic health services. This, he said, was not the case and should be corrected.

The Representative of Tunisia indicated that his country had already put into effect all the recommendations included in the report. He requested that countries be provided with information on the relation between tuberculosis and HIV/AIDS, the reaction of the bacillus causing TB to the drugs used and whether there was any drug resistance.

The Delegate of Cyprus said that there had been 57 new cases in 1993; 10 of these were among foreign workers. Due to new treatment regimes, better living conditions and better surveillance, the recent figures had been considerably reduced. To maintain this low rate, many sectors of the population, particularly those working in the public sector, underwent annual X-rays. Cyprus was making every effort to maintain this low level of disease and the Delegate said that TB specialists preferred the 12-month regimen which provided a 100% cure.

Dr Kochi presented the Headquarters perspective on tuberculosis in various parts of the world. He emphasized the importance of treatment as a first step towards a complete cure; one could then proceed to the identification of cases. He also underlined the importance of the national tuberculosis programme which would permit further epidemiological studies for improvement.

He also spoke of the increased risk of infection among HIV carriers and pointed out that treatment of TB in HIV individuals did not differ from that of the noninfected. He also stressed that any laxity in the fight against TB could lead to the resurgence of the disease as was already happening in many parts of the world. When efforts were coordinated, he added, the cost of treatment could be significantly reduced, which would be a great boost to the national TB programme in developing countries.

The Representative of the Republic of Yemen said that the rate of cure of TB cases in his country did not exceed 36%, which was a low rate. He requested that cooperation between the national programme for TB control and EMRO be increased in order to increase the rate of cure. He also requested support for the programme sponsored by the Japanese International Cooperation Agency (JICA) in the Republic of Yemen. He also enquired about the role which the private sector could play in controlling TB.

The Representative of the Syrian Arab Republic enquired whether it would be preferable to integrate the activities of TB control into the PHC services, and requested that attention be focused on the role of the private sector in TB control. He mentioned that the WHO team within the Joint Programme Review Missions, in view of their knowledge of the situation in the Region, should urge countries to give due attention to TB control activities, as the need arises.

Dr Zuhair Hallaj responded by saying that EMRO planned to support studies on the following:

- the role of the private sector in the field of TB control;
- the resistance of TB bacilli to drugs;
- the integration of TB control activities in PHC services.

5.7 Progress Report on Poliomyelitis Eradication in the Eastern Mediterranean Region

Agenda item 15, Document EM/RC41/13, Resolution EM/RC41/R.16

Dr R. Aslanian, Medical Officer, Eradication/Elimination of Specific Diseases, presented the report. In response to the resolutions of the Regional Committee (1988, 1989 and 1993), as well as those of the World Health Assembly (1988 and 1993), the regional poliomyelitis eradication initiative had made remarkable progress, at both national and regional levels.

In order to implement eradication strategies recommended by WHO, the Regional Office had introduced several key initiatives and activities, namely; assessment of national disease surveillance systems, followed by workshops on disease surveillance; annual subregional meetings to coordinate key activities among neighbouring Member States; and a rapid exchange of information between Member States through a regional monthly bulletin (*PolioFax*).

One of the principal strategies to interrupt circulation of wild poliovirus — conducting national immunization days (NIDs) — was implemented in two countries in 1993 and five in 1994. It was expected that 11 countries would be conducting NIDs in late 1994 and early 1995, during the low poliovirus transmission season. In 1996, all countries in the Region would be conducting NIDs, so that, by 1998, the regional goal of zero polio could be achieved, allowing three years for certification of polio-free status of countries in the Region.

The Regional Office actively promoted the development and the strengthening of national surveillance systems through surveillance assessments and workshops; these had already been conducted in 18 countries. As a result, all the essential elements of high quality polio surveillance, namely the reporting of all cases of acute flaccid paralysis (AFP), case investigations, laboratory-based diagnosis, and 60-day follow-up examinations for residual paralysis, had been established. In addition, the quality and sensitivity of AFP surveillance in these countries was being monitored with standard WHO performance indicators, and these suggested substantial improvements since the assessments were conducted.

An important landmark in the efforts to achieve polio eradication in the EMR was the establishment of three subregional polio-free zones: one for the Arab countries in the Gulf, one for the Arab Maghreb Union, and one in the Middle East. Annual subregional meetings were held in each zone to exchange information and coordinate activities, such as the simultaneous conduct of national immunization days, in order to interrupt circulation of wild poliovirus over a large zone.

Despite these activities and the progress made during 1993, 2451 cases of poliomyelitis were reported to WHO from nine Member States — the largest number reported since 1988 (2342). This increase was attributable to an overall improvement in surveillance for polio and to large outbreaks in Pakistan (1803 cases) and Sudan (252 cases). With NIDs already conducted in five countries, including Pakistan and Sudan, during 1994, it was strongly believed that the number of polio cases reported would decrease substantially, while surveillance continued to improve in the Region. The decrease in the number of cases was already evident, based on the reports for the first half of 1994.

Discussion

The Representatives of the delegation of the Islamic Republic of Iran made a presentation on national immunization days and described the status of polio eradication efforts in his country.

Through routine immunization, it was possible to achieve very high levels of coverage. However, with strengthened surveillance, 107 cases were detected in 1993. An assessment of surveillance was carried out by a joint national/international team. A plan for 2-round National Immunization Days was implemented. He went on to describe the strategies adopted to achieve polio eradication: house-to-house vaccination, enlistment of universities to the cause, training of different categories of workers. Over nine million children were vaccinated against polio with almost 100% coverage.

The Representative of Afghanistan briefly described the constraints faced by the Programme in his country. The national immunization days conducted by Pakistan and the Islamic Republic of Iran covered some of the Afghan refugees in camps in those countries. A mass immunization campaign would be carried out on 19 November throughout the country for which purpose the Islamic Republic of Iran donated eight million doses of vaccine.

The Representative of Sudan stated that a polio epidemic had occurred on the western borders of the country, where about 250 cases had been detected. He emphasized that Sudan did not lack either the financial, or the political commitment, or the general public support necessary for the eradication of polio. However, it lacked vaccines. He called upon countries of the Region to procure these vaccines, within the framework of the cooperative activities that should be institutionalized between them.

The Representative of Pakistan described the activities carried out related to polio eradication. During the last immunization campaign carried out in April and May 1994, 50 million doses, covering 22 million children, were administered. The coverage on the first day was 99.7% and 96.2% on the second day. The next national immunization day would be early in April 1995. The real constraint in the successful implementation of the programme was lack of vaccines and resources. In this respect, he requested the support of WHO and other countries of the Region. The President of the United Arab Emirates had provided US\$0.5 million for the programme. Pakistan was providing information on acute flaccid paralysis cases and this needed to be reflected in the *PolioFax*.

A member of the Bahraini delegation said that her country gave particular attention to polio eradication and that two national immunization campaigns were to be organized from 1 to 7 November 1994, and from 3 to 9 December 1994. It was also planned to administer the polio vaccine to infants immediately after birth, and to reinforce activities of disease surveillance.

The Representative of Morocco requested that the first recommendation included in the report be amended so that it would involve the private sector.

The Representative of Lebanon said that no cases of polio had been recorded in his country during the years 1992 and 1993. However, two cases of AFP had been detected in the summer of 1994; these were immediately followed by an immunization campaign.

The Representative of Saudi Arabia pointed out that his country was implementing national polio eradication activities with perseverance, and that the rate of vaccination coverage had reached 95%. The disease epidemiological surveillance system was also being reinforced and national immunization days were being organized. He enquired about the measures to be applied in case the wild poliovirus moved from a country, where it was epidemic, to another country.

The Representative of Egypt emphasized that his country was undertaking many activities in the field of polio eradication; if any case of polio was detected, then the whole governorate where it had been found was immediately vaccinated. The Ministry of Health had added a fourth dose of polio vaccine that was given to children at the age of nine months. An additional dose of the Salk vaccine was being administered. In addition, two laboratories had been established for isolating and typing the viruses isolated from cases of AFP.

The Representative of the Republic of Yemen said that some of the governorates had not been able to carry out the vaccination of children as scheduled, because of the war. It was planned to organize a national vaccination campaign on 12 October 1994, in addition to three other rounds of vaccination, in cooperation with UNICEF and WHO. He requested information on the method of differentiating between polio and AFP cases.

In reply to the various comments made on the presentation, Dr Aslanian said that in the Islamic Republic of Iran, though reporting was available, the rate of reporting of AFP cases was lower. In reply to the query by Saudi Arabia as to how to prevent reintroduction of polio, he said that in view of the fact that vaccines were not totally effective and that it was difficult to detect viruses, a strong surveillance system was the only strategy that could be effective in prevention. With regard to Pakistan's comment, information on AFP would be included in the *PolioFax* when it was received by EMRO officially.

The Regional Director concluded by saying that he had noticed that most countries of the Region planned to organize national immunization days on various dates. He considered that conducting national immunization days simultaneously, in all the countries, after the month of

Ramadan, i.e. in March 1995 for instance, would prevent spread of poliovirus from one country to another.

5.8 Present Status of Plague and Methods of Control

Agenda Item 19, Resolution EM/RC41/R.1, Decision 3

At the request of the Chairman, and upon the approval of the Regional Committee, Dr. M.H. Wahdan, Director, Integrated Disease Control, gave a presentation on the current status of plague and methods of its control.

Wild plague was found in endemic form in wild rodents in many areas of the world. Infection was transmitted to wild rodents by fleas, and could be transmitted from wild rodents to rodents close to human dwellings, and then from the latter to man - all by fleas. Urban plague, namely infection among rodents and animals living close to human dwellings, had been largely controlled in most parts of the world, particularly following the discovery of pesticides and rodenticides. The plague mortality rate had also been reduced with the discovery of antibiotics.

In the fifties, 75% of plague cases reported to WHO had been from India. However, since the sixties, the number of cases in India had begun to decrease gradually and no cases had appeared since 1967. It was emphasized that the disappearance of infection among human beings did not mean its disappearance among wild rodents. Cases of plague occurred almost annually in six countries, two on each of the continents of Africa, America and Asia.

Human plague manifested in three clinical forms: bubonic, septicaemic and pneumonic, the latter being the most serious type and the only one transmitted from the sick to the healthy by droplets diffused with the sputum of the infected person.

Dr Wahdan dealt with the laboratory diagnosis of plague, and gave the reason for the current situation of plague in India. About a year ago an earthquake had struck Maharashtra State which had resulted in the destruction of numerous burrows of wild rodents. Wild rodents migrated to areas closer to villages and mixed with rodents in inhabited areas, resulting in the transmission of the infection to local rodents and their death. This was followed by occurrences of bubonic plague in Maharashtra State which reached 1190 cases as of September 1994. Pneumonic plague appeared in Surat in the neighbouring state of Gujarat. It was believed that the infection had been transmitted to Surat by workers arriving there from different parts of India. By 24 September 1994, the number of registered cases had exceeded 450, and the number of deaths exceeded 40. More than 300 000 people had left the town for different parts of India. This implied that the infection might have been transmitted to all parts of the country.

Dr Wahdan said that vaccination against plague provided short-term, limited immunity for not more than a few months, which necessitated multiple doses of the vaccine; the immunity thus produced was not absolute and this was not a measure that ensured protection from the disease, particularly in cases of exposure to a more widespread infection. Vaccination was also not a procedure required by travellers as a prerequisite for entering any territory, and was recommended only for public health personnel who deal with patients or rodents or work in laboratories and who should be given preventive doses of antibiotics.

In speaking of the use of insecticides and rodenticides, Dr Wahdan indicated that, when conducting bubonic plague control activities, or dealing with infection reservoirs (rodents), it was necessary to use effective insecticides to kill fleas first, before starting to

eliminate rodents. It was moreover necessary to ensure that the insecticide used was effective.

In conclusion, Dr Wahdan reviewed the measures to be taken by health authorities to prevent transmission of the infection. He referred to articles on the plague in the International Health Regulations, which explained what should be done to prevent the spread of plague by rodents and their ectoparasites, quoting articles 55, 56 and 57. He added that as soon as the news of spread of pneumonic plague in India had been disseminated, the Regional Office in Alexandria had contacted the Regional Office in New Delhi and WHO Headquarters in Geneva, to investigate the epidemiological situation of the disease. He concluded by expressing the hope that this plague outbreak would end in the near future with the help of preventive and control measures taken by Indian authorities, including the widespread use of antibiotics.

Discussion

The Regional Committee approved the Chairman's proposal to have the document published as an information bulletin.

The Director-General of WHO reaffirmed the main points raised in the presentation of Dr Wahdan. He indicated that the Organization had been in continuous contact with India. The current epidemic was an exceptional one. It was actually two epidemics — one in Maharashtra and the other in Gujarat.

WHO extended support to India through the provision of reagents for seroprevalence surveys. The sera were also sent to a WHO collaborating centre in the USA for reconfirmation.

Dr Nakajima then described the chronological development of the disease leading to the present situation.

He commended the measures taken by EMRO to allay the concerns of Member States of the Region, and indicated that another week might be important since the incubation period for the disease was six days. It was possible that the situation might become clearer during the coming week.

He took the opportunity to remind the participants of the need to review, refurbish and upgrade the existing quarantine measures in countries which, in most instances, were not up to the mark to implement the provisions of the International Health Regulations. With the eradication of smallpox, he considered that less attention was being paid to quarantine measures.

The Chairman said that the Gulf Cooperation Council States were currently taking precautionary measures in keeping with the International Health Regulations, and that flights to and from India had been interrupted. He proposed that a technical task force be formed to study the subject and make recommendations for the countries of the Region.

The Representative of Saudi Arabia expressed his appreciation of the efforts exerted by EMRO to provide the countries of the Region with up-to-date information, as it largely ensured the protection of thousands of people in the Region. He emphasized that the measures taken by the Gulf Cooperation Council States did not have any political dimension, and referred to the fact that the Indian authorities had not been cooperative at the onset of the epidemic; Indian ambassadors to foreign countries had initially denied the existence of plague cases.

The Representative of Qatar questioned the information included in the press release issued by WHO Headquarters. He expressed thanks to EMRO for the advice given on the plague epidemic to the Gulf countries, which could be particularly exposed to infection as a result of the regular movement of thousands of workers and travellers to and from India.

The Representative of Oman agreed to the proposal of forming a task force and enquired about its composition and the participation of the different countries of the Region.

The Representative of Egypt noted that all countries of the Region were exposed to danger as a result of international travel, and that they had all decided to take vigorous precautionary measures. Accordingly, and in the light of the presentation made by Dr Wahdan, he believed that recommendations could be formulated on the spot without waiting for a committee to discuss the subject.

The Regional Director stated that WHO formulated recommendations and provided advice about suitable measures to be taken, but that it was the responsibility of the governments themselves to decide on the measures to implement in their respective countries. The proposed task force would review all enquiries made and formulate suitable recommendations for the countries.

The Representative of Morocco affirmed that the role of WHO was confined to providing advice and recommendations to countries and that they had to decide for themselves the measures to be taken.

The Representative of the Libyan Arab Jamahiriya concurred with the proposal of forming a task force, in the light of whose recommendations countries would implement the precautionary measures that would serve their best interests.

The Director-General, in reply to the point raised by Saudi Arabia, said that the International Health Regulations uses the term "infected area" and not "infected country". Presently, many countries did not notify cases of diseases and thus they were violating the provisions of the Regulations. He indicated that the Regulations should be taken seriously and complied with. Since notifiable diseases, such as cholera, when reported in some countries had negative economic repercussions, many countries refrained from notifying them.

There had been no disparity in the figures provided and the Director-General reaffirmed those that were received from the WHO Representative to India (copies of which had been circulated to the delegations).

He considered that any banning of flights may have far-reaching implications and advocated careful consideration of the consequences and prior consultations among other national authorities such as the Ministry of Foreign Affairs, the Ministry of Transport or Civil Aviation.

Dr Wahdan said that the Director-General's intervention had brought up a number of important points, such as when the ban on flights would be lifted, particularly in the light of the provisions of Article 37, which he read out. The task force proposed by the Chairman could consider these points at a meeting in the evening and report to the Regional Committee the following morning.

[Following its establishment, the task force met to consider the status of plague and methods of control. A member of the Delegation of Oman, Dr Ali Bin Gaafar Bin Mohammed Suleiman, presented its report (Annex 5).]

The Representative of the Syrian Arab Republic expressed concern about the lack of clarity regarding cases in statements issuing from Headquarters, as well as their delay.

The Regional Director said that WHO Headquarters could have done better and suggested that in the operative paragraph concerning recommendations to WHO, a sentence also be added requesting that all Member States stay in direct contact in order to take appropriate action in response to the individual situation.

The Representative of Saudi Arabia suggested that the Regional Committee reaffirm the importance of an integrated approach in dealing with this issue and specify what steps should be taken to protect the Gulf countries, as well as providing directives on how to relax the restrictions once the emergency was over.

The Representative of the Islamic Republic of Iran suggested the addition of "suspected" cases, as well as "acknowledgement" of the exhaustive measures taken by the Member States. He added that the Islamic Republic of Iran had taken the same measures as the other countries, with the exception of the flight ban.

The Representative of Kuwait objected to the term "acknowledged". He suggested adding a sentence which would support the action taken by Member States, considered to be necessary in such a critical epidemiological situation.

The Representative of the Syrian Arab Republic said that countries wanted to know if the measures they were carrying out were endorsed, and needed to know that they were acknowledged in the International Health Regulations. He felt that, had India taken such measures to begin with, this situation would not have arisen. He emphasized that the Regional Committee should reaffirm the steps already taken and not just create drafting changes.

The Representative of Yemen outlined the measures his country had taken, supporting the stance of Kuwait and Saudi Arabia and bringing the total number of Member States which had taken firm measures to 11.

The Representative of Pakistan explained that his country's situation was very special as there were extensive borders between Pakistan and India which were used on a daily basis. Pakistan had also taken measures similar to those of some other countries in the Region, but was in a more vulnerable position. He emphasized that the real issue was that WHO must specify measures to be applied by India itself.

The Regional Director stressed that cases should be given their relevant description as either "suspected" or "confirmed" when discussing the number of cases reported in India and said that the report should consider all cases as plague. In studying the draft resolution, he said that it should be kept in mind that WHO recommendations represented a range of actions which depended on many factors. This was a matter of judgement for each individual country. He requested that delegates consider recognizing a range of possible actions. He also suggested the addition of the phrase "according to International Health Regulations", which were used by all countries, and emphasized that a district where plague cases no longer occur for 12 days could be considered plague-free.

The Representative of Kuwait requested that the action of those countries which had taken measures be acknowledged in the document as they had been fully justified in taking those measures.

In conclusion, the Regional Director said that the report of the Task Force, together with the recommendations, would be in the hands of the Director-General on that day.

The Chairman summed up the changes requested in the report and resolution, and these were approved as amended.

At the beginning of the first meeting held on 3 October 1994, the Chairman mentioned that he had received a request for reopening discussions regarding the resolution on plague. The Regional Director called the attention of participants to rule 39 of the Rules of Procedure of the Regional Committee, which stipulated that "when a proposal has been adopted or rejected it may not be reconsidered at the same session of the Committee unless the Committee, by a two-thirds majority of the representatives present and voting, so decides."

Members of the Regional Committee unanimously agreed to the reopening of discussion about the above resolution. The Chairman proposed deletion of the word "independent" from paragraph 4-2 of Resolution EM/RC41/R.1, as well as deletion of paragraph 4-3, as communication with the Indian Government was going on and was not interrupted.

The Committee unanimously adopted Resolution EM/RC41/R.1 as amended.

An informal meeting was held on 4 October at which Mr Inderjit Chaudhuri, Additional Secretary, Indian Ministry of Health, and Dr K.K. Dutta, Director, National Institute of Communicable Diseases, briefed the delegations on the development of and the current plague situation in India, and the actions taken by health authorities at various levels to contain further spread of the disease.

6. TECHNICAL DISCUSSIONS

6.1 The Role of the Community (including NGOs) in AIDS Prevention and Control Activities

Agenda item 8, Document EM/RC41/Tech. Disc./1, Resolution EM/RC41/R.5

Dr M.H. Wahdan, Director, Integrated Disease Control, presented the document. He emphasized that for the success of any public health programme, joint action with community agencies or groups was essential. This was more so in the case of AIDS, as the spread of HIV infection was closely related to many social and community factors, and hence the need for individuals, families and communities to assume greater responsibility for their own health and welfare. He referred to the Regional Committee resolution (EM/RC40/R.6) which urged national authorities to undertake multisectoral approaches involving all national sectors as well as nongovernmental organizations (NGOs) concerned in the fight against AIDS.

He pointed out that the pandemic continued to grow, and during the last year since the Regional Committee met in 1993, there had been an increase of more than 35% in the cumulative total number of cases. The global number of HIV infections had reached over 16 million. In the Eastern Mediterranean Region, more than 2400 cases of AIDS had been reported so far, and it was estimated that at least 100 000 to 150 000 persons could have already been infected. In contrast to earlier years, sexual transmission had become the predominant mode of HIV transmission in the Region. There was now increasing evidence of indigenous transmission in almost all countries of the Region.

AIDS was not just a medical problem, but a social, economic and developmental one as well. It had therefore been acknowledged widely that national programmes should be multisectoral, involving health and other sectors as well as NGOs, to fight the AIDS pandemic in carrying out preventive measures, as well as in providing care and support to HIV infected persons and their families. Such a multisectoral approach remained more of an intent than a reality, although there were examples in some countries of involvement of other sectors in the fight against AIDS, such as those concerned with education, information and religious affairs.

In recognition of the important role that could be played by NGOs, an increasing number of them were now involved in AIDS prevention and control activities around the world, including this Region. Many NGOs were deeply rooted in their local communities and were in close touch with their specific needs and cultural sensitivities. They had credibility, access to communities and flexibility, and were thus in a unique position to make a significant contribution to the fight against AIDS. However, they lacked authority, and, in many cases, resources and funds as well as management expertise. To promote and strengthen their participation in the combat against AIDS, WHO organized a regional workshop in 1991. This was followed by country level meetings which resulted in the development of projects for collaboration with national AIDS programmes. WHO provided financial support during 1992-1993 to the extent of US\$250 000 to 60 projects in ten countries of the Region.

Communities also had a crucial role to play in the prevention of HIV transmission, as well as in providing care and support to people with HIV/AIDS. He said that they must know how HIV was and was not transmitted and how it could be prevented. They needed to be educated about how to protect themselves from HIV. Such education would be successful if it was backed by community commitment and action. The most effective educators were

enlightened insiders, namely trusted people within the community itself. They were effective because they spoke the language of the community and were aware of its cultural sensitivities.

Dr Wahdan emphasized the need to fight denial and the need for a multisectoral programme with high level commitment. He highlighted the important role of NGOs and community participation in AIDS prevention and control, with examples of such roles in the Region.

Discussion

The Representative of Afghanistan said that the 15 years of war had presented the country with so many disease problems that AIDS had not been a primary concern. Also, during the war years, the Afghan population had scattered around the world. Afghans would come back, some of them with AIDS. Afghanistan was also at the crossroads of trade routes, and one had to consider whether Afghanistan would become part of the Asian explosion of AIDS. Afghanistan was primarily rural with extended families and Islamic principles. Extramarital relations were prohibited; illicit relations, if occurring, were all the more hidden, particularly homosexuality. Polygamy was legal, but it was recognized that it increased the risk of AIDS. There were few intravenous drug users. Afghanistan's particular concern was the interaction between tuberculosis and HIV. It was clear, he stated, that Afghanistan now needed to encourage active AIDS prevention.

The Representative of Qatar stated that the report mentioned that the number of AIDS cases had increased by over 30% in only one year, which was very disturbing. He asked if this increase was due to improvement of disease surveillance. He also asked if the cases notified were imported or local ones.

The Representative of Lebanon indicated that the national AIDS programme had been active ever since its inception, undertaking training and health education activities, collection of statistics, and furthering participation in local and regional meetings. Legislation and regulations aimed at promoting AIDS control activities had been established, and the Ministry of Health had allocated a sum in its budget to support the programme and enable it to pursue its activities without bureaucratic constraints. He concluded by expressing the appreciation of his Government for the efforts exerted by EMRO and the WHO Representative's Office in Lebanon.

The Representative of Tunisia commended efforts exerted by EMRO in the field of AIDS prevention and control. He pointed out that the document did not review the composition or the number of nongovernmental organizations involved in control of AIDS. He informed the meeting that Tunisia had applied WHO recommendations concerning the necessity to involve various national sectors and nongovernmental organizations to ensure effective participation while avoiding duplication. It was noted that many of the NGOs did need external support. The OAU summit conference on AIDS which took place in June 1994 ended with the Tunis Declaration emphasizing the need to give the necessary attention to children.

The Representative of Egypt also expressed unease at the statistics showing a 37% increase in AIDS cases in the past year. He underlined the importance his government attached to exact reporting of statistics to WHO. Among the national activities considered of particular importance were the provision of information to the public and surveillance of HIV infection among vulnerable groups. Egypt too believed in and sought the active involvement of NGOs in combating HIV/AIDS. The Representative sought clarification regarding the

news about reduction in funding of programmes for the development of vaccines. He requested that an additional recommendation be included in the report urging coordination between nongovernmental organizations in the countries of the region with a view to uniting their strategies and efforts.

The Representative of the Islamic Republic of Iran noted that his Government was conscious of the threat of a rapid spread of HIV/AIDS, and followed national strategies as recommended by WHO. The monitoring and control activities were truly intersectoral, with several ministries involved, with active members in national AIDS committees. He explained that the national programme activities enjoyed the support of religious leaders, and their spiritual and moral teachings were a source of strength.

The Representative of Bahrain stated that solutions did not lie in recommendations alone; countries had to be encouraged to develop monitoring and diagnosis programmes. He affirmed that the number of imported cases of AIDS had increased in Egypt, being almost double the number of local cases.

The Representative of Cyprus suggested that the global nature of HIV/AIDS represented the greatest threat from any disease in the current century. The active involvement of NGOs in Cyprus was illustrated, pointing out the more effective outreach of many of these to high-risk groups in society. However, sporadic actions were ineffective, and their activities were most valuable when coordinated within a national programme. He noted that none of Cyprus' NGOs had received financial support from WHO. He sought information regarding possible legal implications where an HIV positive deliberately or carelessly transmitted the disease to third parties.

The Representative of Morocco commended the importance attached by EMRO to the AIDS problem and recorded his appreciation of logistic and other support. He indicated the total commitment of the State to support the national HIV/AIDS programmes, and stressed the fact that His Royal Highness the Crown Prince had attended the International Conference on AIDS in Africa, held in Marrakesh in 1993. NGOs were active, and he confirmed that they were more effective at reaching high-risk groups than government authorities. He also stated that problems arose because many of those infected did not reveal their plight, even to their close family relations.

The Representative of Iraq affirmed the priority given by the government to prevent HIV infection and emphasized the importance of coordinating activities between governmental and nongovernmental organizations in the field of AIDS control. He also requested that essential supplies and equipment be made available to his country.

The Representative of the Republic of Yemen pointed out that the national AIDS control programme had been reactivated after the end of the recent war. He noted the existence of maritime frontiers totalling 2400 km between the Republic of Yemen and some of the countries of the Horn of Africa, and that these frontiers might be a path for disease transmission. It was noted that there were positive cases among students returning from academic studies, as well as patients who had had organ transplants abroad. A problem was raised by the return of persons with the disease from countries where they had been diagnosed to have the disease; they had begun their journey in Yemen and they were being sent back to Yemen although they were not Yemeni nationals.

The Representative of Sudan stated that his country had a particular problem in that it bordered on six countries with high prevalence of the disease. He emphasized the importance of health education in combatting the disease.

The Representative of Jordan noted that involving the community in AIDS prevention and control through nongovernmental organizations was an effective means of combating the disease.

The Representative of Kuwait proposed that the AIDS reporting form include additional columns to indicate the nationality of detected cases.

The Representative of Pakistan stated that some 800 cases of HIV/AIDS had been identified, but it was estimated that the true figure was many times higher. There was a national plan to combat the disease, with various AIDS awareness programmes in the media. He felt that it was necessary to strengthen the role played by the community, and give due attention to the needs of the family in the light of the religious and cultural policies associated with the subject of AIDS prevention.

The Representative of the Libyan Arab Jamahiriya suggested that the word "political" preceding the word "commitment" be omitted from the proposed first recommendation and said that an International Centre for AIDS control had been inaugurated.

Dr Merson, Executive Director, Global Programme on AIDS, was invited by the Chairman to comment on and respond to points raised in the discussion.

Dr Merson added his appreciation of the excellent in-depth presentation made by Dr Wahdan to that of the various speakers who had commented in the discussion.

He went on to say that political commitment was the key to success in controlling the disease. It had always to be recognized that the cases of AIDS seen today had been infected up to 10 years previously, and one had to consider how the situation was developing. One could not stop a serious epidemic of AIDS, only control it.

He pointed to the very serious situation in Asia, which was set to overtake the one in Africa if no serious measures were taken. While Africa, Latin America and certain other areas had been infected before the disease was properly recognized, Asia had had the chance to take stronger action and had let the chance slip by. He commended the countries of the EMR for their positive actions in control, and stated that, apart from Djibouti and Sudan, the EMR was the Region with the least problems.

However, he emphasized that HIV/AIDS had to be treated as any other public health problem. The disease must not be stigmatized or considered a taboo. Education and information were the key elements, and here NGOs had a major role to play — in disseminating messages, and promoting prevention and care. NGOs could help society live with AIDS.

In connection with control of travellers, Dr Merson stated that "keeping people in or out" would not help ultimate control. He reiterated that education was essential; open and frank education had to be available to all. Denial had to be fought.

Fidelity in a partnership was the safest practice and had to be encouraged. For others, condoms were still the most effective protection, and those persons had to have easy access to them. It had to be realized that women were exposed to the greatest risk.

Referring to the problem of intentional spread, he confirmed that such cases were rare, and that most countries already had legal instruments to handle any such cases. Such situations could be avoided by arranging for proper counselling of patients.

In response to the question regarding funding of AIDS research in the USA, he informed the Session that, while funding had been reduced for drug trials, it had actually been increased for basic research. It was felt that production of a vaccine was still far off, and that much more had to be known about the disease. In particular, studies had to be made of those persons who, though exposed in high-risk situations, did not get infected, and those 3-5% of cases where, though HIV positive, the persons had remained symptom free for 15 years and more.

He referred to the proposed new UN global programme on AIDS, bringing together UNDP, UNESCO, UNFPA, UNICEF, WHO and the World Bank. In meetings, the heads of these organizations would set the general directions of the programmes, and help select a director and a transitional team to guide the transition process. Dr Nakajima, he pointed out, chaired the group involved in planning future programmes. It had been recognized that Regional Directors were worried what directions the programme might take and the status of WHO in relation to country activities. There was to be a detailed report on progress to the Executive Board in January 1995.

Dr Wahdan, in closing the discussion, pointed out that the paper had only concentrated on a review of the role of the community in the control of AIDS, and it had not been intended to cover the many other important aspects relating to AIDS that were given priority in the various national programmes. Furthermore, the paper did not seek to mention the names of all the nongovernmental organizations working in the field of AIDS, but only gave the names of those organizations supported and assisted by WHO. He noted that a sum had been allocated in each country budget to provide such support.

As regards identification of the "nationality" of cases detected, Dr Wahdan stressed the fact that it had been agreed in a previous session of the Regional Committee that cases would be calculated on the basis of the "place of detection".

7. OTHER MATTERS

7.1 Resolutions and Decisions of Regional Interest Adopted by the Forty-seventh World Health Assembly and by the Executive Board at its Ninety-third and Ninety-fourth Sessions

Agenda item 6, Document EM/RC41/4, Resolution EM/RC41/R.8

The Regional Director drew attention to nine resolutions and decisions adopted by the Executive Board at its ninety-third and ninety-fourth sessions, and 23 resolutions adopted by the Forty-seventh World Health Assembly, highlighting the implications for the Region. He outlined the actions that had already been taken, or that would be taken by the Regional Office to implement the resolutions, and urged Member States to report their own responses.

Discussion

The Representative of Tunisia had indicated that the Technical Discussions represented an important item on the agenda of the Regional Committee and the World Health Assembly's Meetings. The WHO Executive Board had emphasized the importance of the role of the regional offices in coordinating AIDS prevention and control activities; it was therefore suggested that the Regional Committee recommend that the Executive Board's members of the Region emphasize the important role of the regions.

The Representative of the Islamic Republic of Iran said that his country had donated eight million polio vaccine doses to Afghanistan.

The Representative of Afghanistan had expressed his Government's gratitude to the Government of the Islamic Republic of Iran, particularly to the Minister of Health and Medical Education, for the generous assistance.

The Representative of the United Arab Emirates said that coordination should be developed between various programmes and activities within the framework of the Ministry of Health programmes.

The Regional Director commended the discussions and indicated that it was the prerogative of the Regional Committee to decide on whether the Technical Discussions would be included on the agenda of the Committee. As for the role of Regional Offices regarding the AIDS programme, it had not yet been defined or agreed upon. Members of the Regional Committee were expected to confirm the importance of that role and Members from the Region on the Executive Board were also expected to do so.

The Regional Director expressed his appreciation of the support of the Islamic Republic of Iran to Afghanistan, and highlighted the planned visit of an Iranian medical team to Afghanistan in order to assist the implementation of the immunization campaign there.

The Regional Director noted that some of the United Nations agencies sometimes try to have certain programmes outside the supervision of the Ministry of Health, but it should be noted that vertical programmes had not always been successful and were not supported by the Organization, excepting when a vertical programme was merely a new project intended to be integrated with other related programmes and activities, and it had become fully operational.

The Representative of Cyprus considered the resolution of the Health Assembly relating to his own country or to other countries as stereotyped and its adoption an annual ritual. He felt

that Member States from the Eastern Mediterranean Region should take the initiative and sponsor such resolutions, instead of allowing the initiative to pass on to other regions.

With regard to the implementation of these resolutions, he assured that his country had always cooperated with WHO and other United Nations agencies and had acted within the framework of the United Nations and its specialized agencies.

7.2 Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases

Agenda item 16, Document EM/RC41/14, Decision 4

This item was presented by Dr A.M. Khayat, Director, Programme Management. He pointed out that the Joint Coordinating Board consisted of 30 members of whom twelve were government representatives selected by WHO's Regional Committees from among those countries directly affected by the diseases dealt with by the Special Programme, or from among those providing technical or scientific support to the Special Programme. The Board had now two members from the EMR, namely Egypt and Saudi Arabia.

Having shown a slide carrying the names of Member States previously selected by the Regional Committee for the membership of the Board, he pointed out that Djibouti, Oman and Tunisia were among the countries affected by some TDR-targetted diseases and had not had the opportunity of membership on the Board. He mentioned that the Islamic Republic of Iran, Lebanon and Tunisia had expressed their interest in occupying the seat to be vacated by Egypt on 31 December 1994.

The Representative of Morocco supported the nomination of Tunisia. The Representative of Lebanon withdrew the nomination of his country, in favour of Tunisia.

The Representative of the Islamic Republic of Iran said that his country had expressed its wish to be nominated to the Joint Coordinating Board if the Regional Committee so agreed. If there were more than one nomination, he suggested that a vote decide the issue.

The Representative of Cyprus suggested as a compromise solution that, in view of the fact that there would be another vacancy on the Board effective 1 January 1996, Tunisia be nominated to be the member from 1 January 1995 and the Islamic Republic of Iran from 1 January 1996.

The suggestion was accepted unanimously.

It was also agreed that the Islamic Republic of Iran be nominated in the Forty-second Session of the Regional Committee to occupy the seat that would be vacated at the end of 1995.

7.3 Place and Date of the Forty-second Session of the Regional Committee in 1995

Agenda item 17, Document EM/RC41/WP.1, Resolution EM/RC41/R.17

The Regional Committee after hearing the report of the Regional Director on the subject, received two invitations for hosting the Forty-second Session of the Regional Committee, one from Egypt and the other from Pakistan. The Committee decided to hold its Forty-second Session in Cairo, Egypt, in October 1995, and the Forty-third Session in Pakistan, in October 1996.

8. CLOSING SESSION

8.1 Review of Draft Resolutions

Agenda item 20(a)

In the Closing Session, the Regional Committee reviewed the draft resolutions. No changes were requested.

8.2 Adoption of the Resolutions and Report

Agenda item 20(b)

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

8.3 Closing of the Session

Agenda item 20(c), Decision 6

The Chairman expressed the appreciation of the Regional Committee for the action taken by the Director-General of the World Health Organization to implement the recommendations made by the task force established by the Committee to study the subject of plague. A daily bulletin about the epidemiological situation of plague in India was being received. The Regional Committee requested that the daily bulletin should also refer to the situation in the world as a whole, especially in the event of cases of plague occurring in other countries.

The Chairman also expressed the appreciation of the Regional Committee for the action taken by the Director-General who sent a team to survey the situation in India. He mentioned that Member States looked forward to receiving a copy of the report prepared by the team as soon as possible.

The Chairman expressed the satisfaction of the Committee with the decision taken by the Director-General to visit India on 7 October 1994.

The Regional Committee sent telegrams to His Highness the Prince of Bahrain, Sheikh Issa Bin Salman Al Khalifa, His Highness the Prime Minister Khalifa Bin Salman Al Khalifa, and His Highness the Crown Prince, extending its sincere thanks and great appreciation for their kind patronage of the Forty-first Session of the Regional Committee and for the efforts made to ensure its success.

It also sent another telegram to H.E. the Minister of Health of Bahrain, extending its thanks to the Government of Bahrain and to the Ministry of Health for the generous hospitality afforded to the visiting national delegations and the WHO Secretariat, and for the excellent facilities placed at their disposal, which greatly contributed to the success of the Session.

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

The Chairman then declared the Session closed.

9. RESOLUTIONS AND DECISIONS

The following resolutions and decisions were adopted by the Forty-first Session of the Regional Committee for the Eastern Mediterranean (Resolutions EM/RC41/R.1-17, and Decisions 1-6).

9.1 Resolutions

EM/RC41/R.1 **PLAGUE SITUATION IN INDIA**

The Regional Committee,

Noting the data provided by the Director-General of the World Health Organization on the epidemiological situation of the plague, the spread of the disease, the rapid increase in the number of cases and the vagueness of data available to the Organization about the situation in areas where the disease is spreading;

Expressing its concern at the current situation;

Commending the immediate comprehensive actions, concordant with the International Health Regulations, taken by Member States of the Region with the aim of reducing the risk of infection;

1. **THANKS** the Regional Director for the immediate response of the Regional Office to the emergent epidemic situation, and for its prompt supply of essential and useful information about the disease to Member States as soon as available;
2. **RECOMMENDS** that Member States as preventive measures:
 - 2.1 educate the public regarding modes of transmission and methods of prevention;
 - 2.2 ensure the provision of laboratory equipment necessary for diagnosis, and of limited quantities of vaccines to immunize laboratory and field personnel who deal with patients and laboratory samples containing the bacillus;
 - 2.3 inform physicians and other health personnel of the symptoms of plague and the methods of dealing with suspects;
 - 2.4 continue to provide attention to environmental sanitation and the elimination of fleas and rodents with a view to preventing and controlling bubonic plague.
3. **RECOMMENDS** further that, in the event of the occurrence of cases of pneumonic plague, Member States:
 - 3.1 report immediately suspected cases;
 - 3.2 isolate rigorously suspects and apply the necessary precautionary measures to prevent transmission of the infection through droplets;
 - 3.3 disinfect concurrently sputum and articles contaminated with it;
 - 3.4 put contacts under observation, giving them the necessary chemoprophylaxis for a period of seven days;

4. **REQUESTS** the Director-General:

- 4.1 to take the necessary steps to issue a daily circular on the epidemiological situation of plague and measures to be applied;
- 4.2 to take urgent measures to send a team to India to assess the epidemiological situation of the disease;
- 4.3 to inform Member States of the Region of the date on which they could start applying the provisions of paragraph 2 of Article 7 of the International Health Regulations relating to phasing out of preventive measures, taking into consideration the particular situation in the countries of the Region.

EM/RC41/R.2 **ANNUAL REPORT OF THE REGIONAL DIRECTOR**

The Regional Committee,

Having reviewed the Annual Report of the Regional Director on the work of WHO in the Eastern Mediterranean Region for the year 1993², and having noted his statement thereon:

- 1. **THANKS** the Regional Director for his comprehensive report, which reflects the close cooperation between the Regional Office and the Member States;
- 2. **ADOPTS** the Annual Report of the Regional Director;
- 3. **CALLS UPON** Governments of the Region:
 - 3.1 to increase efforts to achieve regional self-sufficiency in essential elements of health care such as vaccines, iodized salt, essential drugs, and basic laboratory and other medical equipment;
 - 3.2 to accord priority to the development of expertise in the area of health care financing and health economics;
 - 3.3 to establish efficient national quality assurance systems support to the provision of good health services;
- 4. **REQUESTS** the Regional Director to pursue contacts with appropriate collaborating centres with a view to drawing on up-to-date expertise as needed on a cost effective basis.

EM/RC41/R.3 **HEALTH ASSISTANCE TO COUNTRIES SUFFERING FROM CIVIL WARS AND COUNTRIES IN NEED OF DRUGS AND MEDICAL SUPPLIES**

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.19 (Provision of material, medical and technical assistance to Somalia) and EM/RC38/R.21 (Assistance to Afghanistan);

² Document EM/RC41/2.

Considering the basic principles in the Constitution of the World Health Organization, which stipulate that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

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

Emphasizing the decision taken by the Eighty-first Session of the Executive Board of the World Health Organization concerning the effects on people's health of withholding medical supplies;

Confirming the successive resolutions of the World Health Assembly concerning the composition of an embargo on medical and food supplies, and the effects of this embargo on health care;

Recognizing the health situation of the Iraqi people and the necessity of enabling them to obtain much needed medical and food supplies;

Referring to the United Nations General Assembly resolution 39/210 that recognized the effects in respect of medical supplies and services as well as health programmes suffered by the Libyan Arab Jamahiriya as a result of the air embargo;

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

1. **CALLS UPON** all Member States and the international community to contribute to assist Afghanistan, Somalia and the Republic of Yemen, and provide the necessary medical support in order to relieve the suffering of the peoples of these countries;
2. **REQUESTS** the Director-General of the World Health Organization and the Regional Director for the Eastern Mediterranean to continue to exert efforts with a view to enabling the Iraqi and the Libyan peoples to obtain their necessary drugs and medical supplies.

EM/RC41/R.4 **PROPOSED PROGRAMME BUDGET FOR THE EASTERN
MEDITERRANEAN REGION FOR THE FINANCIAL PERIOD
1996-1997**

The Regional Committee,

Having considered the Proposed Programme Budget for the Eastern Mediterranean Region for the Financial Period 1996-1997;³

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

³ Document EM/RC41/3.

Noting also that the share of all regions does not exceed 65% of total regular budget funds available to the Organization and that the regional share of extrabudgetary resources is declining;

1. **AGREES** that the fund for Health for All by the Year 2000 - Eastern Mediterranean Region, established under resolution EM/RC31A/R.8, is adequately covered in the Financial Report of the Organization;
2. **RECOMMENDS** that the regional members of the Executive Board as well as representatives to the World Health Assembly continue to undertake initiatives in those forums to increase substantially the regional share of total regular budget resources;
3. **REQUESTS** the Director-General to make available to the EMR an adequate cost increase immediately following the January 1995 session of the Executive Board for use during joint government/WHO programme review missions;
4. **REQUESTS** the Regional Director to:
 - 4.1 undertake efforts to increase extrabudgetary resources for the Region; and
 - 4.2 transmit the Proposed Programme Budget for the Eastern Mediterranean Region, as contained in document EM/RC41/3, to the Director-General for inclusion in his Proposed Budget for the Financial Period 1996-1997.

**EM/RC41/R.5 ROLE OF THE COMMUNITY (INCLUDING NON-
GOVERNMENTAL ORGANIZATIONS) IN AIDS PREVENTION
AND CONTROL ACTIVITIES**

The Regional Committee,

Having reviewed the document for Technical Discussions on the Role of the Community (Including Nongovernmental Organizations) in AIDS Prevention and Control Activities;⁴

Considering the increasing spread of HIV infection in the Region;

Appreciating the AIDS prevention and control efforts made by national authorities, local communities, nongovernmental organizations and WHO;

Recognizing the need to involve actively all sectors of the community and nongovernmental organizations in the fight against AIDS and appreciating the role being played by the Regional AIDS Information Exchange Centre in this regard;

1. **THANKS** the Regional Director for his report;
2. **URGES** Member States to:
 - 2.1 reactivate strong national commitment and provide adequate support for the fight against AIDS, keeping AIDS on the priority agenda;
 - 2.2 continue to fight denial and complacency;
 - 2.3 promote and strengthen active participation of all sectors of the community as well as nongovernmental organizations involved in the fight against AIDS;

⁴ Document EM/RC41/Tech.Disc.1.

- 2.4 enhance educational interventions in the community with particular emphasis on people at increased risk of HIV infection;
 - 2.5 promote the establishment of home and community-based care for persons with HIV/AIDS and their families, including counselling, treatment, palliative care and social support;
 - 2.6 ensure enough resources from within and outside the community to support and sustain the role of the community in AIDS prevention and control;
 - 2.7 ensure coordination among national societies and nongovernmental organizations within the framework of the activities of the national AIDS programme.
3. **REQUESTS** the Regional Director to take the necessary steps to maintain the regional role in prevention and control of AIDS, including information exchange.

EM/RC41/R.6 DIABETES PREVENTION AND CONTROL

The Regional Committee,

Recognizing that diabetes is a chronic health problem that could cause considerable human suffering and that it is attended by severe complications, such as blindness, renal failure, and cardiovascular disease;⁵

Concerned at the significant burden on the public health services resulting from the disease, and the increasing economic costs it provokes in Member States;

Being aware of the need to intensify efforts to prevent and control diabetes;

1. **INVITES** Member States to:
 - 1.1 assess the magnitude of diabetes at the national level;
 - 1.2 initiate national diabetes control programmes for primary prevention of diabetes and secondary prevention of its complications as an integral part of primary health care and in coordination with the health programmes concerned;
 - 1.3 provide the essential elements and acceptable standards of health care for people with diabetes at all levels of the health care system, especially at primary health care centres;
 - 1.4 improve the knowledge of and promote experience in diabetes control, including providing opportunities for training of health manpower in the clinical and public health aspects of diabetes;
 - 1.5 involve nongovernmental organizations and national diabetes associations in national diabetes control programmes;
2. **REQUESTS** the Regional Director to promote the development of educational material appropriate to populations in the Region, and assist countries in strengthening national capabilities in diabetes control.

⁵ Document EM/RC41/10

**EM/RC41/R.7 HEALTH AND MATERIAL ASSISTANCE TO THE
PALESTINIAN PEOPLE**

The Regional Committee,

Recalling its resolution EM/RC40/R.2 by virtue of which Palestine has become a member in the Regional Committee for the Eastern Mediterranean;

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;

Concerned by the deterioration of health conditions in the occupied territories as well as in the liberated territories;

Reaffirming WHO's responsibility for the attainment by the Palestinian people of the highest attainable standard of health;

Trusting that WHO, in the spirit of its Constitution, will exert every possible effort to improve the health conditions of the Palestinian people;

1. **RECOMMENDS** that Member States provide, through bilateral aid or through the Regional Office, material and manpower support to the Palestinian people in order to strengthen their national health services;
2. **RECOMMENDS** that WHO:
 - 2.1 continue the provision of different forms of health support to the Palestinian people, through the Palestinian Governing Authority to enable them to complete as soon as possible the construction of their health infrastructures and services;
 - 2.2 consider opening up a WHO Representative's Office in the liberated territories.

**EM/RC41/R.8 RESOLUTIONS AND DECISIONS OF REGIONAL INTEREST
ADOPTED BY THE FORTY-SEVENTH WORLD HEALTH
ASSEMBLY AND BY THE EXECUTIVE BOARD AT ITS
NINETY-THIRD AND NINETY-FOURTH SESSIONS**

The Regional Committee,

Having noted the presentation made by the Regional Director of the resolutions and decisions of regional interest adopted by the Forty-seventh World Health Assembly and by the Executive Board at its Ninety-third and Ninety-fourth Sessions;

1. **DECIDES** to continue with the practice of including different technical subjects in its agenda;
2. **RECOMMENDS** that the Executive Board include the following item in the agenda of its ninety-fifth session:

Item 22.6 Study of the ECOSOC resolution on increasing resources devoted to the prevention of malaria, diarrhoeal diseases, especially cholera;
3. **REQUESTS** representatives of Member States of the Region serving on the Global Programme on AIDS Management Committee to make known the view-point of Regional Offices in the activities of the United Nations joint and cosponsored HIV/AIDS Programme.

EM/RC41/R.9 **REPORT OF THE REGIONAL CONSULTATIVE COMMITTEE
(EIGHTEENTH MEETING)**

The Regional Committee,

Having considered the report of the Eighteenth Meeting of the Regional Consultative Committee;

1. **ENDORSES** the report of the Regional Consultative Committee; taking into account the comments of the Regional Committee members;
2. **COMMENDS** the Regional Consultative Committee for the advisory support it continues to provide to the Region;
3. **CALLS UPON** Member States to implement the recommendations included in the Regional Consultative Committee report, whenever feasible;
4. **REQUESTS** the Regional Director to implement the recommendations that concern the Eastern Mediterranean Regional Office;
5. **REQUESTS** the Regional Director to continue the practice of putting before the Regional Consultative Committee all important matters intended for consideration by the Regional Committee.

EM/RC41/R.10 **THE NEED FOR NATIONAL PLANNING FOR NURSING AND
MIDWIFERY IN THE EASTERN MEDITERRANEAN REGION**

The Regional Committee,

Having reviewed the Regional Director's report on the need for national planning for nursing and midwifery in the Eastern Mediterranean Region;⁶

Noting the actual and potential role of nursing and midwifery in promoting the health of individuals, the family and the community, as well as in the delivery of care in various health programmes;

Recognizing that effective implementation of national strategies for achieving the goal of health for all requires the availability of sufficient numbers of well-qualified nursing and midwifery personnel;

1. **THANKS** the Regional Director for his report;
2. **URGES** Member States:
 - 2.1 to establish and strengthen nursing units in the Ministries of Health to enable them to undertake a leading role in the development of nursing and midwifery services in the country;
 - 2.2 to give high priority to the development, within the national human resources policy, of plans aimed at improving the quality of nursing and midwifery services and meeting the health needs of the country, including locating nursing schools within the community;
 - 2.3 to provide training at all levels in nursing services management;

⁶ Document EM/RC41/11.

- 2.4 to review and update the existing health legislation relating to nursing and midwifery practice and enact the necessary regulatory mechanisms to support nursing and midwifery practice;
- 2.5 to improve the public image of the nursing profession through mass media and other social marketing approaches in order to encourage both males and females to join the profession.

**EM/RC41/R.11 CHANGING PATTERNS OF DISEASES AND THEIR IMPACT
ON WHO COLLABORATIVE PROGRAMMES**

The Regional Committee,

Having reviewed the technical paper on Changing Patterns of Diseases and their Impact on the WHO Collaborative Programmes;⁷

Noting with satisfaction the changes in the WHO collaborative programmes in response to the changing patterns;

1. **THANKS** the Regional Director for his report;
2. **URGES** Member States:
 - 2.1 to include government health services and private practitioners in the development of national and provincial surveillance systems capable of detecting and documenting the unusual occurrence and status of various emergency diseases;
 - 2.2 to take all possible measures to shape the epidemiological transition in the pattern of diseases in a positive way;
3. **REQUESTS** the Regional Director:
 - 3.1 to designate regional collaborating centres in the field of epidemiological surveillance with effective networking, as appropriate;
 - 3.2 to support research to assist in identifying the determining factors for the epidemiological pattern of diseases of emerging concern.

**EM/RC41/R.12 THIRD REPORT ON MONITORING PROGRESS IN THE
IMPLEMENTATION OF HEALTH-FOR-ALL STRATEGIES**

The Regional Committee,

Having reviewed the Third Regional Report on Monitoring Progress in the Implementation of Health-for-All Strategies;⁸

Noting with satisfaction the progress so far achieved by Member States and the Organization in implementing national and regional health strategies;

Further noting with concern the reduction of financial resources for health development and the resulting set-backs in delivery of services;

⁷ Document EM/RC41/7.

⁸ Document EM/RC41/8.

Realizing that improved health of the population is an investment in socioeconomic development;

1. **THANKS** the Regional Director for his report,
2. **URGES** Member States:
 - 2.1 to continue to transmit to WHO the most recent, reliable data on the various indicators, giving the reference year, in order to provide for meaningful monitoring and evaluation at the regional level;
 - 2.2 to allocate increased public resources to health services, expanding or improving their quality where possible, but at least matching inflation and the rising cost of drugs, equipment and services;
 - 2.3 to rationalize the use of resources available to the health sector.

EM/RC41/R.13 **SUSTAINABILITY OF NATIONAL IMMUNIZATION LEVELS**

The Regional Committee,

Having considered the report of the Regional Director on the sustainability of national immunization levels;⁹

Noting the progress achieved thus far in immunization coverage and control of EPI-preventable diseases in the Region;

Recognizing, however, with concern, that the progress in some countries is not at the rate which would allow their national programmes to reach the targets set by the Children's World Summit, the World Health Assembly, and the Regional Committee;

Realizing that immunization services are one of the most cost-effective strategies in preventing disease;

Reaffirming that the regional targets for immunization programmes are feasible and attainable provided that continuing and sustained national support is ensured;

1. **THANKS** the Regional Director for his report;
2. **WELCOMES** the establishment of a Regional Interagency Coordination Committee to secure extrabudgetary funds for EPI;
3. **URGES** Member States:
 - 3.1 to sustain political and financial commitment to EPI;
 - 3.2 to maintain coordination with other appropriate sectors and NGOs, as well as with influential public figures;
 - 3.3 to ensure an uninterrupted supply of high-quality vaccines and to work together towards achieving regional self-sufficiency in production of vaccines and rationalizing their use;
 - 3.4 to ensure the inclusion of national immunization strategies in the curricula of medical and other health-related schools;

⁹ Document EM/RC41/6.

- 3.5 to continue to ensure public awareness of the need for immunization of children;
- 3.6 to develop a defaulter-retrieval system;
- 3.7 to implement appropriate new and innovative strategies in order to accelerate immunization activities, including linking issuance of birth certificates to having full immunization status, and enactment of appropriate legislation;
- 3.8 to accord special priority to immunizing children in remote areas, and those of displaced people and nomads, where immunization coverage is traditionally low.

EM/RC41/R.14 TUBERCULOSIS CONTROL

The Regional Committee,

Having reviewed the report of the Regional Director on the tuberculosis situation in the Eastern Mediterranean Region;¹⁰

Recognizing the significant progress made in tuberculosis control in the Region,

Concerned about the various factors that are hindering the successful control of tuberculosis in some countries of the Region;

Recalling earlier resolutions on the subject, namely EM/RC36/R.12 (1989), WHA44.8 (1991) and WHA46.36 (1993);

1. **THANKS** the Regional Director for his report;
2. **APPRECIATES** the continuous collaboration of various partners in tuberculosis control in the Region;
3. **URGES** Member States, particularly those with intermediate or high tuberculosis prevalence:
 - 3.1 to develop national tuberculosis control programmes along the strategies adopted by WHO as an integral part of primary health care;
 - 3.2 to conduct research on prevalence of tuberculosis and the resistance of its bacilli to drugs;
 - 3.3 to ensure effective involvement of the private medical sector in tuberculosis control activities;
 - 3.4 to monitor carefully the incidence of TB/HIV coinfection by screening, where feasible, of newly diagnosed tuberculosis cases for HIV infection, always maintaining strict confidentiality;
 - 3.5 to accord tuberculosis control programmes due priority during joint review missions.

¹⁰ Document EM/RC41/12.

EM/RC41/R.15 **WHO RESPONSE TO GLOBAL CHANGE**

The Regional Committee,

Having reviewed the report on the WHO response to global change;¹¹

Having reviewed the method of work of the Regional Committee;

Recalling its resolution EM/RC40/R.4 concerning this subject;

Recognizing the need to establish clear objectives for the ongoing activities based on sound country, regional and global analysis; and

Appreciating the effort made by the development teams at regional and HQ levels;

1. **THANKS** the Regional Director for his report;
2. **RECONFIRMS** its resolution EM/RC40/R.4;
3. **CONSIDERS** that the present method of work of the Regional Committee realizes best the harmonizing of its actions with the work of the Regional Office, other regions, the Executive Board, and the World Health Assembly;
4. **RECOMMENDS** that WHO:
 - 4.1 utilize collaborating centres of excellence to provide up-to-date technical and professional support through the use of a retaining fee;
 - 4.2 consider moving some special WHO programmes to the regions.
5. **BELIEVES** that it is important for regional committees to have a formal say in subjects considered by development teams;
6. **REQUESTS** the Regional Director to convey these views of the Regional Committee to the Executive Board.

EM/RC41/R.16 **POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION**

The Regional Committee,

Having reviewed the Regional Director's progress report on Poliomyelitis Eradication in the Eastern Mediterranean Region;¹²

Appreciating the progress being made towards the goal of poliomyelitis eradication in the Region;

Recalling resolutions EM/RC35/R.14, EM/RC36/R.6 and EM/RC40/R.8;

Recognizing that the achievement of the regional target for poliomyelitis eradication by the year 2000 urgently requires full implementation of WHO-recommended strategies in all Member States, and that this will require additional financial and human resources;

¹¹ Document EM/RC41/9.

¹² Document EM/RC41/13.

1. **THANKS** the Regional Director for his report;
2. **ENDORSES** the updated Plan of Action for Poliomyelitis Eradication in the Eastern Mediterranean Region for the Years 1994-1998;
3. **URGES** Member States:
 - 3.1 to ensure that strong national commitment to poliomyelitis eradication is adopted at all levels and to guarantee the availability of the necessary financial and human resources;
 - 3.2 to ensure mandatory reporting of all cases of acute flaccid paralysis in children aged less than 15 years, with expert clinical, epidemiological and virological investigations and 60-day follow-up;
 - 3.3 to conduct national immunization days with oral polio vaccine, particularly in countries with evidence or risk of wild poliovirus transmission;
 - 3.4 to coordinate the timing of national immunization days between countries in the emerging polio-free zones and the adjacent countries;
 - 3.5 to establish national commissions to ensure the effective functioning of the national polio eradication programme in preparation for certification of poliomyelitis eradication;
 - 3.6 to avail themselves of the opportunity of World Health Day in 1995, with its theme "Target 2000 - A World without Polio" to increase public awareness and establish appropriate policies in this regard;
4. **REQUESTS** the Regional Director:
 - 4.1 to coordinate interregional polio eradication activities with other regions;
 - 4.2 to establish a Regional Commission for Polio Eradication to coordinate between national commissions;
 - 4.3 to continue to seek the additional resources required to achieve polio eradication in the Region by the year 2000.

EM/RC41/R.17 PLACE AND DATE OF THE FORTY-SECOND SESSION OF THE REGIONAL COMMITTEE

The Regional Committee,

Having heard the report of the Regional Director on the subject;

Responding to the two kind invitations extended by the Governments of Egypt and Pakistan to host the Forty-second Session of the Regional Committee;

Decides to hold its Forty-second Session in Cairo, Egypt, in October 1995, and the Forty-third Session in Pakistan in October 1996.

9.2. Decisions

DECISION 1 ELECTION OF OFFICERS

The Regional Committee elected the following officers:

Chairman	H.E. Mr Jawad Salim Al-Arayed (Bahrain)
First Vice-Chairman	Dr Mustafa Kamal El Baath (Syrian Arab Republic)
Second Vice-Chairman	H.E. Mr Manolis Christofides (Cyprus)

Technical Discussions

Chairman	Dr Ahmed Bin Abdul-Kader Al Ghassany (Oman)
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Drafting Committee

Dr Moncef Sidhom (Tunisia)
 Dr Fawzi Abdalla Ameen (Bahrain)
 Dr M.H. Wahdan (EMRO)
 Mr H.N. Abdallah (EMRO)

DECISION 2 ADOPTION OF THE AGENDA

The Regional Committee adopted the Agenda of its Forty-first Session as amended.

DECISION 3 ESTABLISHMENT OF A COMMITTEE (TASK FORCE) ON PLAGUE

The Regional Committee established, at its first meeting, a committee (task force) to discuss the subject of plague; it was to be composed of the following members:

Mr Abdulhamid Azizi (Morocco)
 Dr Mohammedi Azmoudah (Islamic Republic of Iran)
 Dr Mohamed Abdullah Hamdan (United Arab Emirates)
 Dr Ali Bin Jaffer (Oman)
 Dr Alireza Marandi (Islamic Republic of Iran)
 Dr Ameen Abdel Hamid Mishkhas (Saudi Arabia)
 Dr Tawfiq Nasseeb (Bahrain)
 Dr Ali-Said Ali Oun (Egypt)
 Dr Amer Mohamed Raheel (Libyan Arab Jamahiriya)

From WHO, Dr Hiroshi Nakajima, Dr Mohamed Helmy Wahdan and Dr Zoheir Hallaj were requested to participate in the deliberations of the committee.

**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 decided to nominate Tunisia to serve as a member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three year term from 1 January 1995 to 31 December 1997.

DECISION 5 ADOPTION OF THE RESOLUTIONS AND REPORT

The Regional Committee adopted the resolutions and the draft Report of the Forty-first Session.

DECISION 6 CLOSING OF THE SESSION

The Regional Committee decided to send telegrams to His Highness the Prince of Bahrain, Sheikh Issa Bin Salman Al Khalifa, His Highness the Prime Minister Khalifa Bin Salman Al Khalifa, and His Highness the Crown Prince, extending its sincere thanks and great appreciation for their kind patronage of the Forty-first Session of the Regional Committee and for the efforts made to ensure its success.

It also extended its thanks to the Government of Bahrain and to the Ministry of Health for the generous hospitality afforded to the visiting national delegations and the WHO Secretariat, and for the excellent facilities placed at their disposal, which greatly contributed to the success of the Session.

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

Annex 1**AGENDA**

1. Opening of the Session
2. Election of Officers
3. Adoption of the Agenda EM/RC41/1
4. The Work of the World Health Organization in the Eastern Mediterranean Region - Annual Report of the Regional Director for the Year 1993 EM/RC41/2
5. Proposed Programme Budget for the Eastern Mediterranean Region for the Financial Period 1996-1997 EM/RC41/3
6. Resolutions and Decisions of Regional Interest Adopted by the Forty-seventh World Health Assembly and by the Executive Board at its Ninety-third and Ninety-fourth Sessions EM/RC41/4
EM/INF.DOC./1
7. Report of the Regional Consultative Committee (Eighteenth Meeting) EM/RC41/5
8. Technical Discussions: Role of the Community (Including NGOs) in AIDS Prevention and Control Activities EM/RC41/Tech.Disc./1
9. Technical Papers:
 - (a) Sustainability of National Immunization Levels EM/RC41/6
 - (b) Changing Patterns of Diseases and Their Impact on WHO Collaborative Programmes EM/RC41/7
10. Third Report on Monitoring of Progress in the Implementation of Health-for-All Strategies EM/RC41/8
11. WHO Response to Global Change EM/RC41/9
12. Diabetes Prevention and Control EM/RC41/10
13. The Need for National Planning for Nursing and Midwifery in the Eastern Mediterranean Region EM/RC41/11
14. Tuberculosis Control - Progress Report EM/RC41/12
15. Progress Report on Poliomyelitis Eradication in the Eastern Mediterranean Region EM/RC41/13
16. Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases EM/RC41/14

17. Place and Date of the Forty-second Session of the Regional Committee, 1995
18. Other Business
19. Supplementary Item: Present Status of Plague and Methods of Control
20. Closing Session
 - (a) Review of Draft Resolutions
 - (b) Adoption of the Resolutions and Report
 - (c) Closing of the Session

EM/INF.DOC./2

Annex 2

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

**1. REPRESENTATIVES, ALTERNATES AND ADVISERS OF REGIONAL
COMMITTEE MEMBERS**

AFGHANISTAN, ISLAMIC STATE OF

Representative

H.E. Dr S.M. Amin Fatimie
Minister of Public Health
Kabul

BAHRAIN

Representative

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

Alternate

Dr Ibrahim Yacoub
Assistant Under-Secretary
for Primary Care and Public Health
Ministry of Health
Manama

Advisers

Dr Mohamed Khalil Al Haddad
Chief of Medical Staff
Al Salmania Medical Centre
c/o Ministry of Health
Manama

Dr Ahmed Salim Al Arayed
Deputy Chief of Medical Staff
Al Salmania Medical Centre
c/o Ministry of Health
Manama

Dr Fawzi Abdalla Ameen
Chief of Medical Staff
Health Centres Directorate
Ministry of Health
Manama

BAHRAIN (Cont.)

Dr Tawfiq Ali Nasseeb
Deputy Chief of Medical Staff of Health Centres
Ministry of Health
Manama

Dr Ali Mohamed Al Sindi
Consultant Chairman
National Prevention and Control of Diabetes
Ministry of Health
Manama

Dr Naima Al Kassir
Deputy Chief of Nursing
Ministry of Health
Manama

Dr Samir Khalfan
Deputy Director
Public Health Administration
Ministry of Health
Manama

Dr Mona El Sayed Gawad Al-Mousawi
Director of EPI
Ministry of Health
Manama

Dr Fariba Al Durazi
Deputy Director of Training
Ministry of Health
Manama

Dr Hussein Mohamed Kazem Al Aali
Chief, Planning Department
Ministry of Health
Manama

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

CYPRUS

Representative

H.E. Mr Manolis Christofides
Minister of Health
Nicosia

Alternate

Mrs Charitini Komodiki
Chief Health Officer
Ministry of Health
Nicosia

DJIBOUTI

Representative

Dr Chakib Saad Omar
Directeur Technique de la Santé Publique
Ministère de la Santé publique et
des Affaires sociales
Djibouti

Alternate

Mr Ismail Ibrahim Omar
Directeur administratif et financier
Ministère de la Santé publique
et des Affaires sociales
Djibouti

EGYPT

Representative

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

Alternate

Dr Ahmed Soliman Marei
Director-General
General Administration for Foreign Health Relations
Ministry of Health
Cairo

Adviser

Dr Al-Said Ali Oun
Director-General
General Administration for
Communicable Diseases Control
Ministry of Health
Cairo

IRAN, ISLAMIC REPUBLIC OF

Representative

H.E. Dr Alireza Marandi
Minister of Health and Medical Education
Teheran

Alternate

Dr Mohammad Hossein Nicknam
Director-General
Public Relations and International Affairs
Ministry of Health and Medical Education
Teheran

Advisers

Dr Mohammad Azmoodeh
Director-General for Diseases Control Department
Ministry of Health and Medical Education
Teheran

Mrs Fahimeh Rahimiha
Adviser to Ministry of Health and Medical Education
Teheran

IRAQ

Representative

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

Alternate

Dr Nazar Hassan Ali Al-Shabinder
Director General of Planning and Health Education
Ministry of Health
Baghdad

JORDAN

Representative

H.E. Dr Aref Bataineh
Minister of Health
Amman

Alternate

Dr Soliman Affash
Director General of Health Affairs
Al Mafraq Governorate
c/o Ministry of Health
Amman

JORDAN (Cont.)

Advisers

Mr Mustafa Ibrahim Abdalla Qassem
Chief, Department of International Health Relations
Ministry of Health
Amman

Mr Maysaloun George Haddad
Director, Minister's Office
Ministry of Health
Amman

KUWAIT

Representative

H.E. Dr Abdul Rahman Saleh Al Muhailan
Minister of Public Health
Kuwait

Alternate

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

Adviser

Mr Wuqayan Yussef Al-Wuqayan
Director, Minister's Office
Ministry of Public Health
Kuwait

LEBANON

Representative

Dr Walid Said Ammar
Director-General of Public Health
Beirut

Alternate

Dr Hikmat Khedr Assaad
Chief, Registry
Ministry of Health
Beirut

Adviser

Mr Georges Malham Maalouf
Head, International Health Division
Ministry of Health
Beirut

LIBYAN ARAB JAMAHIRIYA

Representative

Dr Amer Mohamed Raheel
Head of Arab Medical University
Benghazi

Alternate

Dr Mabruka El Ghenaïen
Permanent Mission of the Socialist Peoples
Libyan Arab Jamahiriya to the UN Office
Geneva

MOROCCO

Representative

Dr Noureddine Fikri Benbrahim
Chef de la Division de la Coopération
avec les Organisations Internationales
Ministère de la Santé publique
Rabat

Alternate

Mr Abdelhamid Azizi
Directeur de l'Equipeement et du Matériel
Ministère de la Santé publique
Rabat

OMAN

Representative

H.E. Dr Ahmed Bin Abdul-Kader Al Ghassany
Under-Secretary for Health Affairs
Ministry of Health
Muscat

Alternate

Dr Ali Bin Jaffer Bin Mohammed Suleiman
Director General of Health Affairs
Ministry of Health
Muscat

Advisers

Dr Fawzi Rizkalla Gadalla
Health Planning Adviser and Dean Institute of
Health Sciences
Ministry of Health
Muscat

OMAN (Cont.)

Mrs Fatima Bint Abdulla Al-Ghazali
Director of International Relations
Ministry of Health
Muscat

Mrs Sherifa Bint Seif Bin Mohamed Al-Jabri
Nursing Supervisor
Ministry of Health
Muscat

PALESTINE

Representative

Dr Fathi Arafat
President, Higher Health Council for Palestine and
President, Palestine Red Crescent Society
Cairo

PAKISTAN

Representative

Dr Mubasher Riaz Sheikh
Deputy Director-General (Health)
Ministry of Health
Islamabad

QATAR

Representative

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

SAUDI ARABIA

Representative

Dr Abdul Rahman Bin Abdul Aziz Al Sweilam
Deputy Minister for Executive Affairs
Ministry of Health
Riyad

Alternate

Dr Ameen Abdel Hamid Mishkhas
Director of Infectious Diseases
Ministry of Health
Riyad

SAUDI ARABIA (Cont.)

Advisers

Dr Mohamed Abdallah Al Raqf
Head, Nursing Department and Supervisor
of Elderly Programme
Ministry of Health
Riyad

Mr Awwad Al Khattabi
Director, Department of International Health
Ministry of Health
Riyad

SUDAN

Representative

Dr Mohamed Ahmed Abdulla Abu Salab
First Under-Secretary
Federal Ministry of Health
Khartoum

Alternate

Dr Abdalla Ismail
Director-General
International Health Affairs
Federal Ministry of Health
Khartoum

SYRIAN ARAB REPUBLIC

Representative

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

Alternate

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

Adviser

Dr Fayez Al Moai
Director of Tartus Health Directorate
Ministry of Health
Damascus

TUNISIA

Representative

Mr Fethi Merdassi
Secrétaire d'Etat auprès du Ministre
de la Santé publique
Ministère de la Santé publique
Tunis

Alternate

Dr Moncef Sidhom
Directeur des Soins de Santé de Base
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 Mohamed Hamdan Abdulla
Director of Dental Health Services and
Director of Planning and Research
Ministry of Health
Abu Dhabi

Advisers

Mr Nasser Khalifa Al Badoor
Director, Minister's Office
Ministry of Health
Abu Dhabi

Mr Hassan Alkim
Director, Gezira Hospital
Abu Dhabi

Mrs Fatma Youssef Mohamed Al Rifai
Director of Nursing Department
Ministry of Health
Abu Dhabi

REPUBLIC OF YEMEN

Representative

H.E. Dr Nageeb Saeed Ghanem
Minister of Public Health
Sana'a

REPUBLIC OF YEMEN (Cont.)

Alternate

Mr Khaled A.R. Sakkaḥ
Adviser to the Minister
Ministry of Public Health
Sana'a

Adviser

Mr Hashem Awanallah
Adviser to the Minister for International Affairs
Ministry of Public Health
Sana'a

2. OBSERVERS

(Observers from WHO Member States outside the EMR)

ALGERIA

Mr Mohamed Lamine Chergui
Directeur d'Etudes
Ministère de la Santé et de la Population
Algiers

INDIA

Mr Indrajit Chaudhuri
Additional Secretary
Department of Health
Ministry of Health & Family Welfare
New Delhi

Dr K.K. Datta
Director
National Institute of Communicable Diseases
Directorate General of Health Service
New Delhi

(Observers representing United Nations Organizations)

UNITED NATIONS CHILDREN'S FUND (UNICEF)

Mr Saied El Azem
UNICEF Representative
UNICEF Gulf Area Office
Riyad

Mr Abdul Kader Akeel
Head
UNICEF Office
Manama

UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)

Dr Ahmed Botan Dhakkar
Resident Representative
Manama

UNITED NATIONS ENVIRONMENT PROGRAMME (UNEP)

Mr Saleh Mohamed Osman
Regional Director
Manama

Ms Maha Al-Fahoum
Regional Information Communication Officer
Manama

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)

Mr Bhairaja Panday
Assistant Regional Representative
Cairo

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

Dr Mohamed Abdelmoumène
Special Representative of the
Director-General, WHO
Director of Health, UNRWA
Vienna

Dr Arafat Hidmi
Chief, Field Programme, UNRWA
West Bank

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

LEAGUE OF ARAB STATES

Mr Ahmed Kadri Abdel Meguid
Assistant Secretary-General and
Director, Department of Social Affairs
Cairo

Dr Ahmed Safwat Abdel Aziz Safwat
Director, Department of Health and Environment
Cairo

Dr Hussein Abdalla Hammouda
Deputy Director
Department of Health and Environment
Cairo

ORGANIZATION OF AFRICAN UNITY (OAU)

Ambassador Gayama Pascal
Assistant Secretary General
Addis Ababa

HEALTH MINISTERS' COUNCIL FOR GULF COOPERATION COUNCIL STATES

Dr Abdel Rahman Bin Abdel Aziz Al Sweilam
Executive Director
Riyad

Mr Awaad Al-Khatibi
Riyad

Mr Ali Hussein Zawawi
Riyad

GENERAL SECRETARIAT OF THE ORGANIZATION OF ARAB RED CRESCENT
AND RED CROSS SOCIETIES

Mr Galal Abdel Meguid
Representative of the General Secretariat
Jeddah

ARAB BOARD FOR MEDICAL SPECIALIZATIONS (CABMS)

Dr Moufid Jokhadar
Secretary-General
Damascus

Mr Mohamed Sadek Khabbaz
Office Manager
Damascus

ARAB CENTRE FOR MEDICAL LITERATURE (ACML)

Dr Yacoub Ahmed Al Sharrah
Assistant Secretary-General
Kuwait

ARAB UNION OF THE MANUFACTURERS OF PHARMACEUTICALS AND
MEDICAL APPLIANCES

Mr Bassam Ahmed Abdulla Abdel Rehim
Amman

INTERNATIONAL AGENCY FOR THE PREVENTION OF BLINDNESS (IAPB)

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

INTERNATIONAL ASSOCIATION OF CANCER REGISTRIES

Dr Y.T. Omar
Consultant Oncologist
Salmaniya Medical Centre
Manama

INTERNATIONAL CYSTIC FIBROSIS (MUCOVISCIDOSIS) ASSOCIATION

Mr Martin R. Weibel
President, International
Cystic Fibrosis (Mucoviscidosis) Association
Uetendorf
SWITZERLAND

INTERNATIONAL DIABETES FEDERATION

Professor A. Samad Shera
Secretary General
Diabetic Association of Pakistan
Karachi

WORLD FEDERATION FOR MEDICAL EDUCATION (WFME)
AND ASSOCIATION FOR MEDICAL EDUCATION IN THE
EASTERN MEDITERRANEAN REGION (AMEEMR)

Professor Sa'ad Hijazi
President
Association of Medical Education in
the Eastern Mediterranean Region
University of Science and Technology
Irbid

Professor Iain Ledingham
Dean
Faculty of Medicine and Health Sciences
United Arab Emirates University
AlAin

INTERNATIONAL EPIDEMIOLOGICAL ASSOCIATION

Professor Ahmed Mandil
Regional Councillor of IEA
Epidemiology Department
High Institute of Public Health
Alexandria

WORLD ASSOCIATION OF GIRL GUIDES AND GIRL SCOUTS

Mrs Faika Amin
International Commissioner
Manama

Ms Maha Salhani
Representative of the World Association
Manama

WORLD FEDERATION FOR MENTAL HEALTH

Dr Moza Abdullah Al Malki
Representative of the World Federation
for Mental Health
Doha

INTERNATIONAL COUNCIL OF NURSES

Mrs Layla A.R. Murad
Nurse Registrar
Ministry of Health
Manama

ARAB MEDICAL UNION

Dr Abdel Rahman Fakhro
Assistant Secretary General
Manama

ASSOCIATION OF ARAB UNIVERSITIES

Dr Mohamed Adnan Souman
Assistant Secretary General
Amman

Annex 3

ADDRESS BY THE REGIONAL DIRECTOR

May I extend to you a very warm welcome at the opening of this Forty-first Session of the Regional Committee. I pray that our session will be most fruitful, bringing benefit to all the peoples of this Region.

Once again, this august body holds its session in a Member State of this Region, after being hosted by the Regional Office in Alexandria over the last two years. His Excellency, Mr Jawad Al-Arayed, Minister of Health in Bahrain, has taken the initiative and has extended a generous invitation to hold this session in Manama. He thus resumes a well-established tradition in this Region whereby Member States take turns in hosting the Regional Committee sessions. Such a tradition strengthens the sisterly ties among our countries in the Eastern Mediterranean Region as they work to promote the cause of health which is close to the hearts of all people. We are very grateful to the Government, and to the people of Bahrain, for the excellent facilities they have provided to ensure the success of this session.

Ladies and Gentlemen

In the very near future we expect to witness a rare example of the universal support the cause of health can always command. Next month a national campaign of immunization will be implemented in the Islamic Republic of Afghanistan. As you are aware, the immunization programme has been seriously hampered by many years of fighting. All warring factions have now agreed to enable the immunization teams and centres to work in peace and security to provide immunity against killer diseases to millions of children in Afghanistan, which has been enduring a seemingly endless night of internal fighting. We pray to God to allow peace to dawn over Afghanistan, ushering in a period of long-awaited security.

Let us hope that this period of tranquillity, which will allow the immunization campaign to be completed, will be the beginning of a more durable and all-encompassing peace. To achieve that, all our brothers in Afghanistan, irrespective of their different views and philosophies, must hold fast to God's covenant, so that they are never again disunited. They should incline to peace, placing their trust in God and taking positive steps to bring an end to the shedding of blood of innocent civilians. Let us remember that a human being has, in God's view, a far greater sanctity than the Ka'abah, God's Inviolable House.

It is with pleasure that I mention an event that may herald brighter prospects. I am referring to the fact that the Palestinian Health Authority has started its work in parts of the Arab-occupied territories. It was as if the Regional Office were divining the future when, several months before the autonomy agreement was signed, it called for a meeting to formulate a national plan of health for the state which is expected to emerge. We hope that what has been accomplished is only a beginning, shaping a better future for the Palestinian people and helping them to achieve their goals and aspirations for freedom and independence, in a state which they themselves build.

Ladies and Gentlemen

The Regional Committee, which is WHO's top governing body at the regional level, holds its annual sessions to consider the most important questions of health and to chart the

future course for continuing health efforts. As we discuss important health questions this year, we cannot overlook the International Conference on Population and Development convened last month by the United Nations in the Egyptian capital, Cairo. Great expectations were attached to this conference by people throughout the world. It was hoped that the conference would allocate a fair share of its large budget for human development, in order to ensure that people's physical, psychological, social and spiritual needs are fulfilled. Further support would have been expected for the family, which is the nucleus of society and the instrument to ensure stability and a sound social structure. It was most disappointing to see that a large part of the conference deliberations was taken up by futile arguments because a handful of industrial states want to impose their own values on billions of human beings.

By doing so, they expose other nations to the same ills from which they themselves suffer, and which are a consequence of the weakening of the family in their own societies. The collapse of the family, the secure cradle which guarantees a sound upbringing for young children and equips them to resist the temptation of drugs, promiscuity and violence, leads to the sort of problems that create a high rate of suicide, depression and crime.

Had it not been for the positive contribution of political and spiritual leaders of different religions and creeds who attach proper importance to religious and moral values, the recommendations of the conference would have been even further removed from what serves the best interests of mankind. It was certainly fortunate that this conference took place in Cairo, where the advocates of morality and faith had the opportunity to present the moral values cherished by believers throughout the world. It is my belief that I speak for all of us when I reiterate the great importance attached to the family by all the nations of this Region. By the family we mean a husband and wife, united by a legal bond of marriage, enjoying an atmosphere of mutual love and compassion, providing care for those who are close of kin, males and females, young and old, offspring and elderly. They establish a home where women are men's counterfoils, and they conduct their affairs in a congenial manner which promotes all that is good and beneficial. In such a family home the woman is also a shepherd providing physical, mental and educational care for the rest of the family. At the same time, she plays an all-important social role, enjoining what serves the common good, and speaking out against social evil. Like man, she walks along the byways of the earth and eats of what God has provided for us; and like man, she goes about her work, hoping for God's bounty and making her contribution to building civilization and developing her community.

It is to build the structure of the family on a solid foundation, and to spare young men and women unnecessary exposure to the diseases that are rampant in pseudo-civilization, particularly those which are transmitted through promiscuous sex, that we in this Region advocate early marriage.

Marriage establishes a home where mutual love and compassion blossom, which is the best environment to promote mental health. When we advocate early marriage, we are only speaking of marriage at the right time for both man and woman, when each of them has reached the proper stage of physical and mental development. We do not countenance the premature marriage that takes place in some underdeveloped communities where marriage contracts are made even before the couple have attained puberty. Nor do we approve of delaying marriage too long, for such delay burdens young people of both sexes and pushes them towards illicit sex.

We look with endless amazement at the so-called advanced societies as they view, at least with silent approval, sex at an early age, only when it comes through an illegitimate

relationship. Yet they are quick to voice their strong opposition when such a relationship is legitimately established between the same people, at the same age. Who is further in error than one who pursues his wanton desires, following no divine guidance?

We were very happy indeed with the historic resolution approved this year by the World Health Assembly which censures premature sexual relations. We would have liked this stand to be clearly outlined at the Conference on Population and Development, instead of attributing to the World Health Organization an erroneous definition of reproductive health that has not been presented either to the Executive Board of the World Health Organization or the World Health Assembly. Hence, such a definition does not in any way represent the view of the World Health Organization.

As we advocate marriage at an early age, we also advocate family planning for health. This highly appropriate phrase was used in a resolution adopted by the World Health Assembly last year. Hence, it represents WHO's official view. We in the World Health Organization attach great importance to the health dimension of family planning which means the avoidance of pregnancies that are too early, too late, or too frequent. Through early marriage we can protect and promote the sexual and mental health of young men and women. Through family planning for health we promote the physical well-being of both mother and child. We must see to it that the woman receives a reasonable standard of health education, and that she understands her duty to ensure that her children are immunized at the right time. It is the mother who teaches her children healthy eating habits. She imparts positive attitudes to health, steering her children away from exposure to risks that threaten their physical and mental well-being. The mother should be able to oversee the full health care of her family, making sure that all members of the family have the maximum degree of health protection and disease prevention, taking steps to ensure the early detection of illness and administering any medication prescribed by the family doctor. When we have ensured all that I have mentioned, we will enable women to play their full role in society and make their voice heard in the development of the community.

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After speaking about the nucleus, the family, let us turn our attention to society as a whole. In the last few years our world has witnessed a profound change with the end of the Cold War. This great change will continue to have far-reaching effects on the whole world for a long time to come, particularly because it heralded the collapse of a system that boosted the role of the public sector. The new trend to curtail the role of the public sector and limit its domain will inevitably lead to further cuts in government spending on public services, particularly in the fields of health and education. Such a development will give the private sector the opportunity to play a greater role in providing health care.

No one wishes to deny the positive results that accrue when the private health sector assumes a greater role in the provision of health care and curative services. Our standpoint, which considers health a basic human right, makes the provision of health services to all people a duty of the state. Hence, as we move towards giving the private sector a broader role in providing health services, we must ensure that this is preceded by careful study and perceptive planning. Haphazard changes cause what has been built over many years to crumble in no time.

You all know the four major areas of health action, namely, health promotion, disease prevention, curative care and rehabilitation. The private health sector can play a very

important role in providing treatment and rehabilitation services. However, it may often be uneconomical for this sector, considering its perspective and priorities, to obtain certain technologies which give minimal monetary return on very high investment. Hence, the government must closely monitor the services provided by the private sector to ensure high quality and maintain equity. To do that, we certainly need in-depth and careful studies.

Those first two major areas of health action, namely, protection and promotion of health and disease prevention, do not figure among the priorities of the private health sector. Just take as examples environmental health and immunization; more importantly, nor do its physicians pay attention to provision of health education. In these areas, it is the responsibility of the state to play the major role in providing services. These are areas where it must assume the responsibility of surveillance and, where necessary, intervene - as a prime duty of State towards its citizens.

We saw a good example of this in Pakistan, when Prime Minister Benazir Bhutto intervened to check the rapid deterioration of the poliomyelitis situation in her country. Four years ago, immunization against polio in Pakistan had reached a coverage rate of 80%. However, matters deteriorated so fast that recently Pakistan accounted for 22% of all cases of polio throughout the world. Realizing the great danger in this situation, I appealed to the Prime Minister to intervene personally and take the necessary steps to reverse this deteriorating trend. Her response makes me most grateful. The new immunization campaign that she supervised has achieved effective and speedy results. A great improvement in immunization coverage has been reported, providing children with immunity against this disease, which is scheduled for total eradication by the end of the century. Here, I would like to express our gratitude to His Highness Sheikh Zaid Bin Sultan Al Nahyan, the President of the United Arab Emirates, for donating half a million dollars to support the polio programme in Pakistan, and to the Canadian government which donated large quantities of polio vaccine.

On the same subject of poliomyelitis I am pleased to observe that most countries of the Region are making steady progress towards achieving their goal of eradication of polio by the middle of this decade. In the Eastern Mediterranean Region we have two geographical areas, each grouping several Member States, which have almost attained the goal of polio eradication. These two areas are closely followed by a third. However, the pace must be set by the weakest in the party. As long as there continues to be a single country, or a single village where poliomyelitis continues to spread its horror, or even a single case of the disease, then the goal of its eradication will remain distant. Therefore, I urgently appeal to all benevolent people, who are certainly numerous in this Region, to come forward with generous support for the polio eradication initiative. I pray to God to credit their generous contributions as a continuing act of charity which will favourably tilt their balance on the day of judgement.

We have been able to record significant success in combating many communicable diseases, and to eradicate some. We must not, as a result of this success, lose sight of the fact that some diseases may reemerge after having lain dormant for a long or short while. Plague gives us the clearest example. After having disappeared from the Indian sub-continent for nearly 30 years, it has re-emerged in a most worrying way, because its new outbreak is mainly the pneumonic type. It has brought in its wake much fear that has spread all over the world. It is now a major preoccupation of Member States of this Region many of which, through regular population movement and trade, have very close ties with India. It is

important that this disease, and its impact and control, should be carefully considered during this session.

Before I conclude, I should mention that the State of Bahrain, where we are meeting today, was the first country to implement the Action-Oriented School Health Programme. His Excellency, Dr Ali Fakhro, the Minister of Education, has been kind enough to prepare a programme showing details of this pioneering experience. We will have a chance to see this programme during this session.

I would also like to extend a very warm welcome to our observer brothers who have honoured this session with their presence. They will undoubtedly enrich our discussions with their contributions. May I particularly mention the representative of Algeria, a country which has historically had very close relations with the Member States of this Region. I also welcome the representatives of sister United Nations Organizations, the Arab League and its different agencies, the Organization of African Unity, the Arab Medical Association, the Association of Arab Universities, the General Secretariat of the Organization of the Arab Red Crescent and Red Cross Societies and other specialized associations.

Your Committee has a number of highly important topics on its agenda. Undoubtedly these topics shall receive frank and constructive discussion, which is characteristic of all its sessions. With God's help, your deliberations will lead to great benefits for the peoples of this Region. May God bless your meeting and render your discussions fruitful.

Annex 4

ADDRESS BY THE DIRECTOR-GENERAL

Mr Chairman, Honourable representatives, Colleagues, Ladies and gentlemen,

This year, the governing bodies of WHO are focusing on reform in the regions. By the end of 1994, all WHO regions should have designed and started implementing what, in the global reform process, pertains to their own areas of competence and authority. In 1994, I presented the Executive Board and Health Assembly with reports and updates on reform as carried out at headquarters. In 1995, our governing bodies will expect to hear from the Regional Directors about how the regions have moved forward and harmonized WHO'S reform process.

Much of the final success of WHO's reform is now in the hands of the regions and the Regional Committees. Since direct technical cooperation with countries is a major *raison d'être* of the Organization, priorities in WHO's programme budget are set to meet the needs expressed by the regions for health development in their countries. The Director-General, however, can and does propose global priorities to reach the common goals and fulfil the joint commitments of the whole membership of the Organization.

There are signs that the world economic crisis might be subsiding. The conclusions of the G-7 Summit in Naples last July were less gloomy than they have been in the recent past. Some countries which are going through a particularly difficult economic transition have had their debt burden reduced. However, the overall situation remains precarious and it is likely that the least developed countries will continue to experience economic hardship and its social consequences.

In this time of uncertain economic prospects, rich and poor countries alike are facing increased costs in the social sector, particularly in health care, where new technology and the information explosion have stimulated the demand for health services. Thus governments, under financial strain, will continue to look for opportunities, both at home and in their aid policies, to enforce stringent economies. The backlash has been felt directly by the United Nations system. WHO itself has been affected by shortfalls in contributions and a continuing zero growth budget in real terms, and we cannot expect this situation to improve in the immediate future.

The role of the United Nations has been shifting towards the management of complex emergency and humanitarian situations, in the interest of peace-keeping and under the guidance of the Security Council. This has greatly added to our operational and financial responsibilities.

In a changing world environment, health - as a focus of human rights and humanitarian responsibilities - has broken out of its biomedical and technical dimension to become a major political issue. We know that health gets money when it becomes a political issue. But where primary health care has been viewed as part of a social safety net only, and limited to providing for basic minimum needs, then, often too little consideration has been given to such issues as disease prevention, health promotion and education, environmental

health, and health research. In other words, the importance of health to development has been often neglected by economists, economic planners and politicians.

The United Nations, in its effort to focus on better coordination, efficiency and value for money, has to some extent lost the vision of its role in socioeconomic development. People, especially taxpayers in major donor countries, are showing less interest in the United Nations specialized agencies, giving more attention to nongovernmental organizations which now have a total expenditure amounting to at least ten times the whole United Nations budget. On the other hand, however, the World Bank and the International Monetary Fund, heavily criticized by countries for past policies, have recently recognized the need to include significant lending for investment in health as a component of the structural adjustment process.

With the conclusion of the Uruguay Round of international trade negotiations, a new organization will be established next year in Geneva. This is an major change for international trade which will also have consequences on health policies, cooperation and co-activation, in which WHO plays an important role.

In this environment, we must differentiate between higher and lower priorities. We must keep our activities under constant scrutiny and be prepared either to upgrade them to meet evolving needs or phase them out when they have outlived their usefulness or can no longer benefit from our comparative advantage. Marginal activities can only be maintained at the cost of more pressing health needs. They will not even succeed in protecting jobs, as many international partners will soon turn away from what they see as irrelevant programmes and uncooperative agencies.

The ball is in our court. Our programme budget proposals must be selective, focusing on a limited number of priorities, defined to meet the urgent needs of countries while promoting our common long-term goals. We must make it clear that we know where we are headed, and that we have the competence to achieve the goals we have set with the resources at our disposal; that our programmes are action-oriented, managed efficiently, and that their expected outcomes justify the disbursement of scarce resources by external partners. In other words, we must demonstrate accountability. There is fierce competition for funding today, at the international level just as within national environments. And unless we can make a better case than others, we will lose out and our cash-flow will dry up.

This necessary and painful exercise has its risks. To some extent, choices will be influenced not only by objective criteria, but also by personal judgments, and by the mood of the day and of society, which is so often distorted by the media. If malaria today has made such a savage comeback, it is to a large extent because, for a long time, it could not get the public's attention and could not qualify as a priority with external partners. This only illustrates my point that we must be constantly on the watch, monitor our health activities and review dormant or emerging health issues. These may be the priorities or, if left unattended, the emergencies of tomorrow. The recent outbreak of plague in India has clearly demonstrated this.

At Headquarters, we have worked at focusing on priority areas partly by restructuring and partly by revising the classified list of programmes, which we are now proposing to reduce to 19 items. Progress in the streamlining of programmes and management has been steady, but there is still a long way to go. And we cannot travel that road much further unless countries and regions now join in and support our effort to design and implement reform at all

levels of WHO's global network. Together, we can bring this exercise to a successful conclusion.

It is gratifying to note that last year, in spite of severe constraints on staff and budget, we were able to record encouraging results in a number of important fields. First of all, outside the health sector but with major implications for the lives, health and welfare of all the peoples of the region, the historic Peace accord and the implementation of self-rule in Gaza and Jericho opened a new era of peace, cooperation and development, which fills us all with hope and happiness. WHO is now stepping up its technical cooperation activities in support of the development of a comprehensive health care system for the Palestinian people. The Palestinian participation in this Regional Committee can only be beneficial to all and is a welcome contribution to the universality of health and of our Organization.

The first International Conference on Elimination of Leprosy was held in Viet Nam in July 1994. It reported remarkable success but also warned against the dangers of complacency and slackening of efforts. It unanimously adopted "the Hanoi Declaration" which calls for even stronger political and financial commitment to the goal of eliminating leprosy. Nine years after the introduction of multidrug therapy, the total number of leprosy cases worldwide has been reduced by 70%. In 1994 alone, the number of cases dropped by 23%. The target we set for ourselves in 1991 of eliminating leprosy as a public health problem by the year 2000 is now well within our reach. To accelerate progress, a special programme will be set up.

I wish to pay tribute to all our partners, particularly in the nongovernmental and voluntary organizations, who have given us invaluable support in this effort. This is an outstanding example of what can be achieved through expanded partnerships for health. The need to foster partnership and coordination has been fully recognized within WHO itself where the responsibility for leprosy activities is shared by the Special Programme for Research and Training in Tropical Diseases (TDR), which is supported by extrabudgetary funding, and the Division of Control of Tropical Diseases (CTD), which is financed by the Regular Budget.

Similarly, at the global level, steady progress has been made towards our goal of eradicating poliomyelitis by the year 2000. While we must view with concern the 24% increase in polio incidence reported last year for the Eastern Mediterranean Region, we must also recognize this as an indication of great improvement in the epidemiological surveillance system. In their commitment to eradication Member States of the Region have made every effort to strengthen surveillance as the key to attaining polio-free status for their own people. To complete our work, we must intensify our outreach to remote and marginalized groups in all countries and regions. We must also provide against shortages either of vaccine or of trained personnel. The firm commitment of political and public health leaders and the continued support of the international community especially of UNICEF and Rotary International, are essential to the final eradication of poliomyelitis.

In Tunis, in June 1994, the Summit of the Organization of African Unity put the issue of Children and AIDS in Africa on its agenda and emphasized the importance of extending prevention efforts, in particular to the young and within the family environment. The African heads of state also stressed the need for concrete social and economic measures in support of families and children affected by HIV/AIDS. In August, the Tenth International Conference on HIV/AIDS and Sexually Transmitted Diseases, held in Yokohama, called attention to the rapid spread of the pandemic in South and South-East Asia. It took stock of the new findings

emerging from research, which point to a very complex host-virus relationship and to the marked specificity of the human response to the disease.

The Yokohama Conference strengthened and expanded its partnerships, calling more particularly for the involvement of people living with HIV/AIDS in the fight against the pandemic. The Conference confirmed WHO's leading role and unique competence in the global fight against HIV/AIDS. Within the United Nations Joint and Cosponsored Programme on HIV/AIDS, WHO will maintain this leadership and its constitutional responsibility for directing and coordinating international health work.

In Paris, on 1 December 1994, the AIDS Summit will be convened under the cosponsored of France and WHO. Political leaders, at the highest level, will commit their governments to the global fight against AIDS. New initiatives and mechanisms will be launched, particularly for research, blood safety, vaccines and drug supply, in support of equitable access to prevention and care for developing countries.

In April 1993, WHO declared tuberculosis a global emergency. It is currently estimated that, worldwide, tuberculosis kills about 3 million people each year, more adults than any other infectious disease. The HIV-AIDS pandemic has contributed to boosting the global threat from tuberculosis. Other important factors have been the poor quality and chronic underfunding of many TB control programmes, poverty, uncontrolled urbanization, breakdowns in drug supply and deterioration of health care services caused by the economic crisis.

It is imperative that we gain the upper hand in tuberculosis control while short-course chemotherapy provide us with a highly cost-effective tool for control of the disease. Missing this opportunity and giving drug-resistance a chance to develop would have dire consequences for all countries and people. This is a lesson we learned the hard way from our experience with malaria.

Health is both a major determinant and an outcome of development. Sustainable and integrated health development requires solidarity, both at the national and international levels, but countries need to put their money where their priorities are. Countries must harness all their available resources for the health of their people. This can and must be done in all countries, including those in crisis and conflict, and those which have suffered setbacks in the past caused by uncoordinated national and international cooperation policies.

New social and economic structures, especially increased privatization, call for new approaches to health management and cooperation. WHO will continue to promote enlarged partnerships for health involving all social and professional sectors. The nature and scope of people's participation in health development itself has changed considerably since the Alma-Ata Declaration. Nongovernmental organizations, communities and patients themselves are playing an increasingly active role in advocacy and political lobbying, as well as disease prevention, health care and rehabilitation. WHO's recently formulated concept of "family health", for example, promotes the involvement of the whole family unit in maintaining the health of all its members throughout their lives. This was part of our message to the International Conference on Population and Development, which concluded its work in Cairo some days ago.

In the end, the Cairo Conference was able to reach a consensus and a promising Plan of Action, rallying to WHO's position on family planning. WHO has advocated that family planning should be part of reproductive health, and that reproductive health services must be

integrated in all primary health care services and made available to all people. The Cairo Conference has set a remarkable example of how health can be instrumental, not only in promoting development, but also in helping to avoid political confrontation and resolve potential conflicts of civilizations. We can say that health, and WHO, contributed significantly to the final and important success of the Cairo Conference.

Whether for family health, essential drugs, human resource development, immunization, or health financing and management, WHO is ready to cooperate with countries in defining their needs and to bring them direct technical support at all levels. But first, the regions and countries themselves must select and rank their priorities. Needs will have to be defined and tasks distributed in coordination between countries, regional offices and headquarters.

This is why WHO urgently needs a management information system which ensures compatibility throughout our global network. The system has to be designed and set up jointly, to facilitate communication, problem-solving, and the rapid exchange of information, especially in complex emergency situations, - in addition to supporting the execution, coordination and monitoring of our common programme and budget.

Similarly, the review of the role and functions of WHO's country offices and representatives has to be finalized and the necessary changes introduced so that WHO can contribute as effectively as possible to health and social development at country level. Our objective must be to enhance WHO's direct support to the Ministries of Health as well as WHO's ability to promote, coordinate and integrate health interventions within future United Nations unified teams and actions at country level.

Global political and economic change over the past few years has imposed the updating and reform of health policies. Health for All remains our basic goal and is as fundamental as any other basic human right. Equity in access to health care remains a responsibility of government and is the fundamental issue of health ethics as expressed by the majority of heads of delegation at this year's Health Assembly. But, today, equitable provision of health care requires the participation of a far wider spectrum of providers and beneficiaries than was envisaged at Alma-Ata in 1978. Disease remains the problem, but the people affected by diseases are not problems; they are part of the solutions which, together, we must define and implement.

Our new partnership for health will be founded on this ethical vision. Respect for the dignity and rights of individuals, whether sick or healthy, is the starting point. Informed responsibility, however, on the part of individuals within their families and communities, is also of vital importance. A health care system developed by government should be at the centre of national development policy. Involvement and commitment at the highest political level of the state, together with the people, are of the utmost importance in establishing this new partnership in health. WHO will continuously extend its technical cooperation at all levels to support the efforts of government and of people, to achieve Health for All, and Health by All, to prepare for the coming 21st century.

Thank you.

Annex 5

**REPORT OF THE COMMITTEE (TASK FORCE) ESTABLISHED
TO DISCUSS THE SUBJECT OF PLAGUE**

The Committee was composed of the following members:

- Dr Mohamed Abdullah Hamdan (United Arab Emirates);
- Dr Tawfiq Nasseeb (Bahrain);
- Dr Amer Mohamed Raheel (Libyan Arab Jamahiriya);
- H.E. Dr Alireza Marandi (Islamic Republic of Iran);
- Dr Mohammadi Azmoudah (Islamic Republic of Iran);
- Dr Ali Bin Jaffer (Oman);
- Dr Al-Said Ali Oun (Egypt);
- Mr Abdulhamid Azizi (Morocco);
- Dr Ameen Abdel Hamid Mishkhas (Saudi Arabia).

Members of the WHO Secretariat attending the meeting were Dr Hiroshi Nakajima, Dr Mohamed Helmy Wahdan and Dr Zoheir Hallaj. His Excellency Dr Alireza Marandi was elected to chair the meeting.

The task force reviewed the current situation of plague in India, in the light of the new data provided by the Director-General of WHO on the epidemiological situation of the disease. It also reviewed articles relating to the subject in the International Health Regulations (attachment), and a detailed presentation was made on the precautionary health measures that had been taken by the Gulf Cooperation Council States and other countries of the Region in the face of the epidemic. Having considered the data available to WHO, it became clear that:

- 1) the spread of the disease in India was continuing;
- 2) the number of cases has been rapidly increasing in the last few days (897 new cases in the last 24 hours);
- 3) statements coming from India were still obscure; for instance, these statements did not differentiate between bubonic and pneumonic plague, nor between primary and secondary pneumonic plague cases;

- 4) the Indian health authorities were not applying the articles of the International Health Regulations relating to reporting cases or the implementation of other necessary measures.

It was also clear to the task force that:

- The large number of workers coming from India to the Gulf area, estimated to be several thousand daily, greatly increased the risk of transmission of infection to the Region and to other parts of the world. There was difficulty in applying health regulations and measures to such large numbers. Measures comprise surveillance, diagnosis, isolation and provision of chemoprophylaxis because the symptoms of pneumonic plague were similar to those of many other common diseases. A number of infected people do not show symptoms if the disease is still in the incubation period.
- The Middle East, particularly the Gulf area, has been, historically and epidemiologically, the first point of contact at which epidemic disease could be transmitted from Asia to Africa, Europe and America.
- The closure of schools, cinemas and other places of public assembly on the part of the local authorities in New Delhi was proof enough that the situation in India was serious.

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The task force commended the exhaustive measures taken by most of the Member States in the Region, and their immediate application, including those health precautions stipulated in the International Health Regulations, with no delay no discrimination, and in complete conformity with article 24 of the above Regulations (attachment).

It also commended the immediate response of the Regional Office to the emergency, its rapid supply of essential and useful information on the disease to the Member States - quickly

answering any inquiries, and informing them of any data that became available to it as soon as it was received.

The task force then proposed the following recommendations to the Regional Committee.

I. Recommending that health authorities in all recipient countries take the following measures:

A) Preventive measures that aim at decreasing the risk of exposure to the disease:

- (1) educating the public regarding methods of exposure to infection;
- (2) ensuring the provision of laboratory equipment necessary for diagnosis, and of limited quantities of vaccines to immunize laboratory and field personnel, and those who deal with patients and laboratory samples containing the bacillus;
- (3) informing physicians and other health personnel of the symptoms of plague and the methods of dealing with suspects;
- (4) continuing to provide attention to environmental sanitation and the elimination of fleas and rodents with a view to preventing and controlling bubonic plague.

B) Measures relating to pneumonic plague patients and contacts:

- (1) immediate reporting of suspected cases;
- (2) rigorous isolation of suspects and application of necessary precautionary measures to prevent the transmission of the infection through droplets;
- (3) concurrent disinfection of sputum and articles contaminated with it;

- (4) putting contacts under observation, giving them the necessary chemoprophylaxis for a period of seven days.

C) International Health Regulations

It has been necessary to put into effect the precautionary health measures stipulated in the International Health Regulations, immediately and without discrimination, particularly the provisions of the articles presented in the attachment.

II. **Recommendations to WHO:**

- (a) a daily information circular be issued on the epidemiological situation of the plague;
- (b) the Director-General take the necessary measures to send a team to India to assess the epidemiological situation;
- (c) the Director-General contact the Indian government, urging it to apply all measures stipulated in the International Health Regulations.

ATTACHMENT**MAIN PROVISIONS RELATING TO PLAGUE STIPULATED
IN THE INTERNATIONAL HEALTH REGULATIONS**

- Article (3) stipulates that: "Each health administration shall notify the Organization within twenty-four hours of its being informed that the first case of a plague, is neither an imported case nor a transferred case, and, within the subsequent twenty-four hours, notify the infected area".
- Article (6) stipulates that: "During an epidemic the notifications and information required under Article 3 shall be followed by subsequent communications sent at regular intervals to the Organization. These communications shall be as frequent and as detailed as possible. The precautions taken to prevent the spread of the disease, in particular the measures which are being applied to prevent the spread of the disease to other territories by public means of transport shall be stated".
- Article (11) stipulates that: "The Organization shall send to all health administrations, as soon as possible all epidemiological and other information which it has received under Article 3 as well as information as to the absence of any returns required. The Organization may, with the consent of the government concerned, investigate any plague outbreak".
- Article (24) stipulates that: "Health measures shall be initiated forthwith, completed without delay, and applied without discrimination".
- Article (30) relating to "health measures on departure" stipulates that: "The health authority for a port or an airport or for the area in which a frontier post is situated shall take all practicable measures to prevent the departure of any infected person or suspect".
- The section relating to the plague, in Part V of the International Health Regulations, details the measures to be taken by the health administrations in infected areas, and the health authorities in recipient countries. Article 55 stipulates that: "Before departure on an international voyage from an area where there is an epidemic of pulmonary plague, every suspect shall be placed in isolation by the health authority for a period of six days,

reckoned from the date of the last exposure to infection"; and Article 56 stipulates that: "A ship or an aircraft shall be regarded as infected if it has a person on board who has been exposed to pulmonary plague and has not met the requirements of Article 55".

Annex 6

FINAL LIST OF DOCUMENTS, RESOLUTIONS AND DECISIONS

1. Regional Committee Documents

EM/RC41/1	Adoption of Agenda
EM/RC41/2	The Work of the World Health Organization in the Eastern Mediterranean Region - Annual Report of the Regional Director for the Year 1993
EM/RC41/3	Proposed Programme Budget for the Eastern Mediterranean Region for the Financial Period 1996-1997
EM/RC41/4 EM/INF.DOC./1	Resolutions and Decisions of Regional Interest Adopted by the Forty-seventh World Health Assembly and by the Executive Board at its Ninety-third and Ninety-fourth Sessions
EM/RC41/5	Report of the Regional Consultative Committee (Eighteenth Meeting)
EM/RC41/Tech.Disc/1	Technical Discussions: Role of the Community (including NGOs) in AIDS Prevention and Control Activities
EM/RC41/6	Technical Paper: Sustainability of National Immunization Levels
EM/RC41/7	Technical Paper: Changing Patterns of Diseases and Their Impact on WHO Collaborative Programmes
EM/RC41/8	Third Report on Monitoring of Progress in the Implementation of Health-for-All Strategies
EM/RC41/9	WHO Response to Global Change
EM/RC41/10	Diabetes Prevention and Control
EM/RC41/11	The Need for National Planning for Nursing and Midwifery in the Eastern Mediterranean Region
EM/RC41/12	Tuberculosis Control - Progress Report

EM/RC41/13	Progress Report on Poliomyelitis Eradication in the Eastern Mediterranean Region
EM/RC41/14	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases
EM/INF.DOC./2	Supplementary Item: Present Status of Plague and Methods of Control

2. Resolutions

EM/RC41/R.1	Plague Situation in India
EM/RC41/R.2	Annual Report of the Regional Director
EM/RC41/R.3	Health Assistance to Countries Suffering from Civil Wars and Countries in Need of Drugs and Medical Supplies
EM/RC41/R.4	Proposed Programme Budget for the Eastern Mediterranean Region for the Financial Period 1996-1997
EM/RC41/R.5	Role of the Community (including Nongovernmental Organizations) in AIDS Prevention and Control Activities
EM/RC41/R.6	Diabetes Prevention and Control
EM/RC41/R.7	Health and Material Assistance to the Palestinian People
EM/RC41/R.8	Resolutions and Decisions of Regional Interest adopted by the Forty-seventh World Health Assembly and by the Executive Board at its Ninety-third and Ninety-fourth Sessions
EM/RC41/R.9	Report of the Regional Consultative Committee (Eighteenth Meeting)
EM/RC41/R.10	The need for National Planning for Nursing and Midwifery in the Eastern Mediterranean Region
EM/RC41/R.11	Changing Patterns of Diseases and Their Impact on WHO Collaborative Programmes

EM/RC41/R.12	Third Report on Monitoring Progress in the Implementation of Health-for-All Strategies
EM/RC41/R.13	Sustainability of National Immunization Levels
EM/RC41/R.14	Tuberculosis Control
EM/RC41/R.15	WHO Response to Global Change
EM/RC41/R.16	Poliomyelitis Eradication in the Eastern Mediterranean Region
EM/RC41/R.17	Place and Date of the Forty-second Session of the Regional Committee

3. Decisions

Decision 1	Election of Officers
Decision 2	Adoption of the Agenda
Decision 3	Establishment of a Committee (task force) on Plague
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	Adoption of the Resolutions and Report
Decision 6	Closing of the Session