

Report of
The Regional Committee
for the
Eastern Mediterranean
Forty-fifth Session

Beirut, Lebanon
3–6 October 1998



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1. INTRODUCTION

The Forty-fifth Session of the Regional Committee for the Eastern Mediterranean was held at the Coral Beach Hotel, Beirut, Lebanon, from 3 to 6 October 1998. The opening session was held at UNESCO Palace. The other sessions were held at the Ambassador Hall of the Coral Beach Hotel. The Technical Discussions on Regional Self-sufficiency in Vaccine and Drug Production were held on 5 October 1998.

The following Member States were represented at the Session:

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

In addition, observers from the United Nations Programme on HIV/AIDS (UNAIDS), International Labour Organization (ILO), United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), League of Arab States, World Bank and a number of intergovernmental and nongovernmental and national organizations attended the Session.

2. OPENING MEETING AND PROCEDURAL MATTERS

2.1 Opening of the Session

Agenda item 1

The opening session of the Forty-fifth Session of the Regional Committee for the Eastern Mediterranean was held at the UNESCO Palace, Beirut, Lebanon.

H.E. Dr Mohammad Farhadi, Minister of Health and Medical Education, Islamic Republic of Iran, and Chairman of the Forty-fourth Session of the Regional Committee extended sincere gratitude to the Government of Lebanon and to H.E. Mr Sleiman Frangieh, Minister of Public Health, for hosting the Forty-fifth Session of the Regional Committee and wished the Session great success. He thanked Dr Hiroshi Nakajima, previous WHO Director-General, for his efforts to implement WHO health objectives, and congratulated Dr Gro Harlem Brundtland on her appointment as the new Director-General, wishing her and her colleagues every success in their work.

He outlined some of the health achievements in the Region and described the great strides taken in the promotion of peoples' health, as detailed in the Regional Director's report. Despite these achievements, he said, the Region had been hit by crises, and WHO had had to shoulder critical and sensitive responsibilities. The US missile attack against a Sudanese pharmaceutical factory, the miserable health conditions of the Palestinian people and the spread of dangerous chronic diseases following massacres in Afghanistan had worsened health conditions in the Region.

The Minister expressed his belief that the main task of the health sector at national, regional and global levels was to identify resources and mobilize them at the proper time. However, the public did not fully participate in health activities. Nongovernmental organizations had not become sufficiently involved in programmes. Other developmental sectors that could play a key role in the execution of health programmes did not feel obliged to participate, and in many countries high-ranking authorities were not fully engaged in their health responsibilities.

Dr Farhadi referred to the new WHO management standard operating procedures proposed by Dr Brundtland, who had proposed sixfold axes as the principles of the operation and structure of the Organization. If put into practice, these could open up a new chapter in the Organization's function which would revolutionize international health activities. Some of the outstanding aspects of her plan of action were fighting communicable diseases, benefiting more from Member States' and the WHO regions' recommendations, establishing effective relations with relevant international organizations, holding joint sessions with the private sector, and conducting an anti-smoking campaign. He reaffirmed that the Eastern Mediterranean Region, as usual, was ready to assist the Director-General through providing clear guidelines. He added that one of the main issues in the allocation of funds to the regional programme was determining comprehensive health indices, so that the interest of the regions, including the Eastern Mediterranean Region, with respect to their health, cultural and socioeconomic characteristics, should be respected. Another important issue

was the spiritual and mental health of human beings, which was always on the Eastern Mediterranean Region's agenda.

In conclusion, he said that the World Health Organization could achieve the objectives set only if it adopted a suitable dynamic and can-do structure. Therefore, the suggested structural change in the new management should be verified by the Member States and Regional Committees to ensure full collaboration of the Organization with the least bureaucracy and the most decentralization possible in future.

2.2 Address by H.E. Mr Sleiman Frangieh, Minister of Public Health, Lebanon

H.E. Mr Sleiman Frangieh, Minister of Public Health of Lebanon, welcomed the participants to the Session. He said that the civil war in Lebanon had destroyed confidence in government hospitals and had led to a rapid growth of private sector health services which were not commensurate with the actual needs of the country. He went on to say that the Ministry of Public Health had prepared a health reform programme, to be implemented in stages, to promote prevention, rationalize treatment, reform the financing system, determine an appropriate modern role for the Ministry, and ensure the autonomy of government hospitals so as to re-establish confidence in the sector and enable it to compete with the private sector. The health reform project, he said, was based on a number of principles: that health was a right and should never be subject to exploitation under the pretext of market economy and freedom of industry and commerce; that health expenditures were an essential investment in the social development process; that health care provision was a duty of the state; and that health for all could be achieved only if everyone was a partner in the health scene.

Describing some of the recent health achievements in Lebanon, Mr Frangieh mentioned the marked reduction in infant mortality, the increase in life expectancy and the success of immunization campaigns. He expressed appreciation for WHO contributions in Lebanon. The Minister announced the full commitment of Lebanon to the health-for-all objectives declared by WHO, particularly those relating to equity and sustainable health development. He also confirmed the Ministry of Public Health's support for WHO's call for the achievement of a just peace based on the implementation of international resolutions, to put an end to conflicts and alleviate their terrible impact on human health.

In conclusion, Mr Frangieh reaffirmed his belief that radical reform of the health system was inevitable and expressed hope that Lebanon would once more become the treatment centre of the Middle East.

2.3 Opening address by the Regional Director

Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean, expressed his gratitude to H.E. President Elias Hraoui for having agreed to inaugurate this Session and wished Lebanon greater stability, prosperity and happiness for the future. He added that the Regional Committee was particularly delighted to welcome Dr Gro Harlem Brundtland, WHO Director-General, who was attending its meetings for the first time since her election.

She would undoubtedly note, he said, some of the characteristics of the Region which distinguished its countries, notwithstanding its vast area and the ethnic differences between its peoples. These characteristics tended to serve the cause of health and to make health work more fruitful, as they were derived from the inherent cultural values of the Region, based on Islam and Christianity, the two great religions in which the overwhelming majority of the peoples of this Region believed.

The family in the Region, he said, was closely knit, and its bond was firm. From the Eastern Mediterranean cultural perspective, the family was the nucleus of society and its basic unit. The values that prevailed in the Region established ties of mutual compassion, love and solidarity throughout society. The same ties formed the underlying basis of family relationships. The Regional Director then stated that as health was the special field of interest of the Committee, and was considered an essential human right, the strong family ties in this Region were highly useful in facilitating health work. The theme of this year's World Health Day emphasized the importance of mothers' health, an essential sector of society, under whose feet God had placed heaven, as He had set dutifulness to one's mother precedent over all obligations of care and help. It was most important, he stated, to make use of such feelings of love and dutifulness to make all the community aware of the need to take special care of women's health along the path of safe motherhood right from childhood.

The theme of next year's World Health Day, he added, would concentrate on the health of the elderly. The cultural values that prevailed throughout the Region laid special emphasis on showing genuine respect for elderly people and taking good care of them. A person who did not respect elderly people or give them their due measure of love and care did not belong to us. If old people's homes were relatively few in number in the Region, he said, this was because we consider the natural place for the elderly to be with their families, who can make use of their mature vision and wisdom. The Regional Director then said that Lebanon had provided an example of how such values worked in practice. The managers of two neighbouring institutions, an orphanage and an old people's home, had agreed that the elderly people should help in looking after the young ones in the orphanage. The children gave back the elderly a sense of purpose, thus the lives of these elderly people regained their meaning as they realized that they were doing something particularly useful that filled up their previously monotonous days. The young ones learnt from their patient and good-natured companions how to acquire good manners and to observe sound moral values.

The Regional Director also suggested that due consideration be given to another concept that fitted in perfectly with the values and ideals of this Region, namely, the adoption of elderly people into families, so that they might live within a natural family environment. They would receive good care from the families who adopted them, and the adopting family would also gain from the experience, wisdom and advice of their new elderly members.

A great advantage of the characteristically closely knit family in the communities of the Eastern Mediterranean Region was that it had prevented the spread of some diseases. It had, for example, he said, a much better AIDS situation than other regions. For this privileged situation the Region was undoubtedly indebted to the moral and religious values

that prevailed; to the closely knit family, and the prevalence of faithful marriage. However, that favourable position should not be allowed to induce an air of complacency in our attitude to AIDS. The Regional Director emphasized in this connection the advantages of early marriage, providing the physical and mental growth of the young couple had been completed, and provided early marriage was coupled with strict family planning.

He also emphasized that breastfeeding was the normal practice in the Eastern Mediterranean Region. It was readily accepted by parents, as it represented a cultural value that was well entrenched in the family structure in the Region. He noted with gratification the progress that some countries of the Region had achieved in their efforts to return to breastfeeding and to re-establish it as the norm.

He added that an important aspect of maintaining children's health that fitted in with essential cultural values in the Region was immunization. To neglect immunization was to expose young children to the risks of disease. It also meant leaving them to perish, and according to our values, that was sinful. As the Prophet Muhammad ﷺ said: "It is sufficient of a sin for any person to allow his dependants to perish." The Regional Director called upon the health authorities to maintain high rates of immunization coverage and to improve these rates year after year.

It was essential, he said, to strengthen surveillance systems for target diseases, particularly those for poliomyelitis and acute flaccid paralysis. He urged those Member States which still had weak surveillance systems to strengthen such systems, and stressed the importance of full cooperation on the part of the private sector with the surveillance systems. Efforts aiming at the eradication of poliomyelitis should continue. The goal could not be considered to have been achieved until the last remaining pockets of disease had been completely purged and the disease had been definitely and finally eradicated from every area throughout the whole world.

The Regional Director then stated that the epidemic which he considered more difficult to eliminate than both poliomyelitis and measles together was one which presented an unparalleled list of health risks: smoking. It was the only epidemic that was actively promoted by certain interests. In the world today, he said, one person died every nine seconds from a tobacco-related disease. Unless everyone joined ranks in a determined effort to reverse this tragic situation, it would deteriorate even further and in less than 25 years time there would be one death every three seconds from a tobacco-related disease. He warned against the activities of the tobacco companies, which, having lost a large chunk of their markets in developed countries, had turned their attention to the developing countries. He stressed the importance of countries of the Region working in unison and concentrating their efforts on increasing everyone's awareness, but particularly that of the younger generations, that smoking was harmful to health, socially unacceptable and forbidden in religion. He commended the proposal of the Mufti of Egypt that each packet of cigarettes sold in the Region should carry, in addition to the health warning, a religious warning saying: "Smoking is forbidden by religion". This would bring religious influence, which was strong in the Region, to bear upon the cause.

He then took up another distinctive characteristic of the Region, namely, social solidarity. It was firmly rooted in people's minds, he said, explaining that this was the underlying reason for the spectacular success of the Basic Development Needs initiative in countries of the Region. The practical application of the Basic Development Needs initiative in 13 Member States had proved beyond any doubt that the response of the local communities in poor and deprived areas was both positive and natural. They found in it an approach that was akin to their ideals, dealt directly with their situations, and made use of their own potential, which was rarely turned to advantage by the traditional methods. He expressed, in this connection, great satisfaction at the fact that the Government of Pakistan had approved the Basic Development Needs initiative as a national strategy for poverty alleviation, and had allocated in its federal budget more than US\$ 400 million for the implementation of the strategy throughout Pakistan over the coming five years.

In conclusion, the Regional Director reviewed the immense challenges faced by countries of the Region, and set by what was known as the new world order. Foremost among these changes, he stated, was the powerful trend towards globalization, with all that entailed in terms of freedom of trade, including the area of health services, and the great revolution in information technology. It was expected, he said, that these developments would lead to a fundamental change in the health sector. It was also expected that this would be coupled with negative effects on the health systems in developing countries, and a fundamental reassessment of the roles of the State and the private sector in providing such services. He called upon the leadership of the health sector, particularly ministries of health to try to bring about a situation which would accomplish the reform of the health sector within the framework of a national health policy that set well-defined national goals to meet the essential health needs of the whole population.

He ended his address by expressing sincere thanks and gratitude to the Lebanese Government for hosting this Session of the Regional Committee, and particularly commended the efforts it had made and the excellent facilities it had provided to ensure the success of the Session.

(Annex 3 contains the full text of the Regional Director's address.)

2.4 Address by the Director-General

Dr Gro Harlem Brundtland, Director-General of the World Health Organization, expressed her delight at being in Lebanon, a source of hope and inspiration, with such a distinguished group of health leaders. The Regional Committees represented an extraordinary opportunity to tap the experiences of health officials around the world, she said. WHO was complete only if the regional dimensions were included.

She referred to the advantages of having a broad perspective on health since important determinants of better health, such as education, environment, poverty, armed conflict and excessive military expenditure, lay outside the health system. The health challenges could not be fully appreciated or addressed by focusing only on the health sector. There were, she noted, many peoples in the Eastern Mediterranean Region faced with armed conflict, and

WHO needed to add its efforts to the prevention of conflict. She called on more countries to ratify the treaty banning the use of anti-personnel landmines, which had recently come into force with 40 ratifications, including two from the Region so far. WHO, said Dr Brundtland, had to emphasize the message of peace to the international community, peace being an absolute need for sustainable health and human development, and to aid the victims of conflict.

Right and timely investments in health benefited society at large, she continued. Investing in health gave tangible results in terms of less social and economic cost, more human progress and enhanced capacity for society to harness the human resources that would be at the forefront of development in the 21st century. It was essential to advocate for health and to put health at the centre of the development agenda. This would mean gathering evidence, matching it with that of others, becoming better advocates and reaching decision-makers with a convincing case, which in turn required new methods of work.

Dr Brundtland then moved to the advantages of reaching out to other United Nations agencies, to other key players in health and to civil society in this interdependent world. WHO, she said, could be a stronger lead agency in health by entering into partnerships of stakeholders. It should focus on problems that crossed boundaries, on generating and disseminating a global evidence base, and on promoting research that went beyond corporate or national agendas. In this way WHO would provide the intellectual and moral leadership required to ensure health for all.

These themes of partnership and focus applied, she said, to the work of WHO in the Eastern Mediterranean Region. It was important to maintain close contacts with the regional structures of United Nations partners and with other regional institutions, including those in the economic field. This would enable the development of better strategies for linking health and trade issues, such as harmonization of occupational and environmental health standards, balancing the mandate to protect the health of people from potential hazards of trade with the use of health regulations as trade barriers, as well as new areas such as the trade in health-related services and products.

WHO would engage the private sector in constructive dialogue and this would be of critical importance with regard to the pharmaceutical sector. National and international drug policies should help extend access to essential drugs of good quality, safety and efficacy. This required strong national regulatory authorities and intelligent government purchasing policies.

Upgrading national capacities not only in production but also in the quality assurance of locally manufactured drugs and vaccines was an important priority. National strategies must ensure equity of access, rational use and assured quality of existing drugs. Issues of drug financing and affordability were critical. At the same time, to meet pressing public health needs new drugs and vaccines were needed. This required innovative industry research, with appropriate incentives for innovation and protection of intellectual property rights. International organizations and governments should address pharmaceuticals issues within their areas of competence and responsibility, in order for these important issues to be

handled in a satisfactory and timely manner. Dr Brundtland referred in this regard to her forthcoming discussions with the Director-General of the World Trade Organization on ways to further both international commerce and international commitments to health.

Turning to the shift in the global burden of disease from communicable to noncommunicable diseases, the Director-General noted the double burden that both types of disease posed. Many countries were still suffering from common infections and reproductive health problems. Without having fully solved these challenges, they were already facing the emerging problems of more prevalent noncommunicable diseases and new infections. It was a common misconception that communicable diseases would be mostly the problem of the poor and noncommunicable diseases would affect the rest of the population; in fact the poor suffered higher rates of both types of disease.

Dr Brundtland noted the dramatic progress achieved in poliomyelitis eradication in the most difficult areas of Afghanistan, northern Iraq, Pakistan, Somalia, Sudan and the Republic of Yemen, but also stressed that the momentum of the worldwide initiative for elimination must be maintained. It was feared that the eradication campaign might be running critically short of funding. It was estimated that US\$ 600 million would be needed till the end of 2000, and she called on all countries to make a reinforced effort led from the top.

Dr Brundtland reminded the Committee of her pledge to lead WHO in a renewed international effort to Roll Back Malaria. In the most heavily affected countries this would need strengthened health systems. The project staff were currently preparing the work in close dialogue with the Regional Offices. With regard to tuberculosis, she noted that more than 90% of the tuberculosis in the Region was concentrated in eight countries. She commended regional efforts but noted that incidence and mortality of tuberculosis in the Region would increase over the next 10 years without further major effort and closer work with WHO's partners.

Referring to the initiatives that had already begun in some countries of the Region on community-based intervention programmes for primary care of noncommunicable diseases, the Director-General called for developing a regional network. Serious focus must be placed also on controlling risk factors of noncommunicable diseases of which tobacco was by far the most important. Referring to the magnitude of tobacco-related deaths in the Region, Dr Brundtland emphasized the message: tobacco is a killer. It should not be advertised, subsidized or glamorized, and adolescents should not be allowed to mortgage their lives to the seductive advertisements of the industry. WHO's new Tobacco Free Initiative aimed at galvanizing global support for tobacco control. It was essential to ensure that the policy was backed by people, money and institutions, not just in Geneva, but also in the regions and within all Member States. World No-Tobacco Day 1999 would focus on creating opportunities for health professionals, governments, nongovernmental organizations, the media and pharmaceutical companies to work together towards a common goal.

Dr Brundtland then referred to the worldwide movement for health system reform, for which she saw three concrete goals: measurable reduction in the huge inequities within and

across countries; sustained, measurable reduction in the burden of disease; and universal access to efficient health services that respected the needs and dignity of each individual. A key responsibility for governments should be to secure access to care. Only the public sector could guarantee basic universal rights, a useful reminder that 1998 was the 50th anniversary of the Universal Declaration of Human Rights as well as of WHO's Constitution.

While the performance of market forces had enormously increased productivity in many sectors of the world economy, including health, the private sector was seldom the key provider of primary health care or health services for the poor, nor would it ensure universal access. Discussion on norms and standards of a "new universalism"—a new way of addressing universal coverage—was necessary and would be a WHO priority. Governments should provide strategic leadership, accepting that there were limits to the amount of care governments can finance. WHO would be available to advise on which efforts would have the best impact, reach the most people and achieve the most effective results. Provision of government-financed service must come from the most efficient source, not necessarily from public sector providers.

An essential function of WHO was to mobilize international collective action to ensure that information on experience gained was effectively produced and disseminated. A "cluster" called Evidence and Information for Policy, one of nine such clusters, had been created and the knowledge base it contained was for the use of all Member States.

She stated that she wished to establish and maintain a closer contact with the Regional Directors, with the WHO country representatives, with the Executive Board, with the private sector and with nongovernmental organizations.

The Director-General concluded by noting that science had provided powerful tools. The need now was for political, financial and ethical commitment to face the challenges of the future—that called for evidence-based and value-driven action.

(Annex 4 contains the full text of the Director-General's address.)

2.5 Address by H.E. Mr Elias Hraoui, President of Lebanon

H.E. Mr Elias Hraoui, President of Lebanon, welcomed the delegations to the Forty-fifth Session of the Regional Committee for the Eastern Mediterranean and paid tribute to the new Director-General, stating that the Member States were relying on her input to modernize the face of the Organization as well as its role in the world.

Despite the devastation left by the ordeal endured by Lebanon, said Mr Hraoui, the country had succeeded in rehabilitating the provision of health services in the country thanks to cooperation between the public and the private health sectors and nongovernmental organizations. In recent years, he said, Lebanon had witnessed a rapid improvement in the availability of state-of-the art medical equipment and technology and a rise in the number of dispensaries and health centres scattered around its various regions. Lebanon was exerting great efforts to increase the efficiency of the health sector through a national strategy aimed

at providing health for all, and national expenditure on health increased, reaching last year nearly 10% of the national income.

Needs however exceeded capacity. The preservation of health was not guaranteed only by dispensing therapy; there was also a need to enhance the activity to fight, for example, environmental problems. But such an approach required technical and material support.

Mr Hraoui commended the humanitarian assistance extended to Lebanon by WHO during the ordeal and the Organization's contribution to increasing the effectiveness of the role of the civil sector. He expressed his appreciation for the pioneering role played by WHO in securing technical, consultative, financial and administrative support for many health projects and programmes.

Lebanon, while consolidating the edifice of state, hoped to define health priorities at the national level, to focus on the importance of prevention, not only cure, in public health and to concentrate on guaranteeing excellence in the provisions of health services, emphasizing that Lebanon relied on the support of WHO to make headway in this endeavour.

The world, in general, and our Region, in particular, were in need of new health orientations. For the health of the people derived from the health of nature; hence the need to increase cooperation between the health, the environment and the information sectors.

Mr Hraoui concluded by saying that the Lebanese government wanted this meeting to represent a milestone in the history of the Organization, its mission and its role; and a milestone in the history of the relations between the Organization and Lebanon.

2.6 Election of officers

Agenda item 2, Decision 1

The Regional Committee elected the following officers:

Chairman:	H.E. Mr Sleiman Frangieh (Lebanon)
First Vice-Chairman:	H.E. Dr El-Hédi M'henni (Tunisia)
Second Vice-Chairman:	H.E. Dr Abdallah Abd El Waly Nasher (Republic of Yemen)

Dr Wagida Abdel Rahman Anwar (Egypt) was elected chairman for the technical discussions and Dr Mabruka Legnain (Libyan Arab Jamahiriya) co-chairman.

The Regional Committee decided that the following should constitute the Drafting Committee:

Dr Ali Bin Jaffar Bin Mohammed Suleiman (Oman)
Dr Moncef Sidhom (Tunisia)
Mr Ismail Akbari (Bahrain)

Dr Mohammad Helmy Wahdan (EMRO)

Dr Abdel Aziz Saleh (EMRO)

Mr Hassan Naguib Abdalla (EMRO)

2.7 Adoption of the agenda

Agenda item 3, Document EM/RC45/I Rev.1, Decision 2

The Regional Committee adopted the agenda of its Forty-fifth Session.

2.8 Discussions and comments on the Director-General's address

H.E. the Minister of Health of the Syrian Arab Republic requested the Director-General, when choosing people to represent a region at meetings, to consult the region concerned so that the interests of the region were taken into account.

H.E. the Minister of Health of Bahrain, referring to the distribution of the regional allocations, expressed the concern of all the Eastern Mediterranean Region at the reduction that it had suffered. Those countries that had worked hard to improve their health indicators would lose out in their country allocations. With regard to the double burden of communicable and noncommunicable diseases now being witnessed he hoped that the Region would maintain a balance in its allocations to both aspects of the burden.

H.E. the Minister of Health and Population of Egypt called for greater sharing on the part of the Member States in the decision-making of World Health Organization, noting that many countries felt they lacked influence in this regard. The ministers of health of the Region were a resource for the Director-General and could add value and commitment in WHO. It was ironic, he said, that the current reduction in regional activities did not match the need for greater commitment to health in the Region. He called on the Director-General also to ensure that her team followed up on her visit and discussions with ministers to ensure that momentum was not lost and the process of consultation was continued. He hoped that the Director-General would do her best to address the unfairness that had resulted from the new regional allocations and suggested greater application of extrabudgetary funds to the Eastern Mediterranean Region to re-establish the balance. He suggested also that savings might be made by relocating certain programmes now in Geneva to more appropriate and cheaper locations. On the subject of health sector reform the Minister of Health and Population stated that it was a difficult medicine for developing countries to swallow. He acknowledged, however, that it must be done, and WHO could help in this regard. He called on WHO also, as the defender of health for all, to assist in addressing the problems that would arise for countries in application of the World Trade Organization Agreements, particularly that on Trade-Related Aspects of Intellectual Property Rights (TRIPS). He also said that the move towards reducing regional activities was not consonant with the move towards the 21st century. It was important to strengthen interregional activities. In addition to this request that Member States have a greater share in decision-making, he also called upon the management team appointed by the Director-General to consult the regions and share with them the decision-making process. He emphasized the importance of close

working procedures between the "owners" of the Organization—the ministers of health—and the management of WHO. There should be no separation.

The Representative of Jordan welcomed the internal reform the Director-General had initiated in WHO which, he said, reflected the spirit of reform that was ongoing everywhere. He called for WHO to ensure a balance between its normative role and its capacity-building role. While acknowledging the potential flexibility offered by extrabudgetary funding, he cautioned against the mischannelling of such funding as this could hamper implementation of ongoing programmes. Finally, he expressed his appreciation of the Director-General's intention to open dialogue with WHO at all levels.

H.E. the Federal Minister of Health of Sudan commended the Director-General's interest in promoting development in all countries of the Region and was particularly pleased with her call to Roll Back Malaria, which was a major problem in Sudan. He commented on her use of the phrase "southern Sudan" saying that he would prefer references to Sudan since the Sudanese regarded their country as one unit.

H.E. the Minister of Public Health of Tunisia stated that the issues emphasized by the Director-General as being of interest were shared by his country and that his country had high hopes of the Region's efficiency. He pointed to the necessity of giving priority in the Region to all aspects of life, mainly to that of the Region's budget, the decentralization of projects and to the programmes implemented by WHO. He emphasized that Tunisia could assume a leading role in some programmes, such as those relating to disease prevention and control. He added that this might lead to rationalization of expenditures. He attacked the high prices of some drugs, particularly those for the treatment of certain tumours. He wondered how it was that the price of oil was fixed globally while that of drugs was fixed by the manufacturers only.

H.E. the Minister of Health of Iraq noted that the Director-General had mentioned some of the prevalent diseases in some countries, including Iraq. He pointed out the necessity of focusing on the totality of health systems in all countries of the Region and invited the Director-General to conduct field visits to observe methods of disease prevention and control. He objected very much to the reduction in allocations to the Region and pointed out the efficiency of countries of the Region in dealing with health problems. He added that he supported the attention devoted to the issue of drugs and commended the efforts of the Regional Office in providing his country with the results of the tests conducted on bioavailability.

H.E. the Minister of Health of Saudi Arabia expressed bitterness and dissatisfaction at the reductions made in the regional allocations and objected to the principle of reducing the budget of one region to the benefit of another. He wondered whether countries of the Region were being punished for improving their health services by reducing their budget, when they should be assisted further in continuing to develop their health services and facilities..

H.E. the Minister of Public Health of Kuwait said that the Director-General's speech reflected her ambition for greater achievements in global health, which he welcomed. He

echoed the concerns of other representatives concerning budget cuts and regional allocations and called for greater efforts in mobilizing extrabudgetary resources and encouraging efficiency in implementation.

H.E. the Minister of Public Health of the Republic of Yemen noted that despite WHO's many contributions to health improvement in the Region, some countries suffered tremendously from the double burden of communicable and noncommunicable diseases. He called for greater global equity in budgetary allocation and increased support for the least developed countries. He welcomed the trend towards health sector reform and requested greater technical and financial support from WHO in this regard.

H.E. Dr Abdel Rahman Al-Awadi, Chairman of the Islamic Organization for Medical Sciences, warned that many countries of the Region were suffering from poverty and that the future seemed to herald further suffering and challenges. He requested the Director-General to consider budgetary distribution in the light of the realities of the situation and the specific nature of the Region.

Comments by the Director-General on interventions by delegations

Dr Brundtland thanked the Member States for their comments, saying that she was pleased to see a general sentiment among Member States, other partners and WHO staff for WHO to do its best for the people of the world.

She acknowledged that the regional perspective was important and that the Regional Offices were a strength of WHO through which differences in culture and socioeconomic status could be highlighted as well as differences in health status and needs. Any attempt to improve the health of all required a coherent global approach, bringing together country and regional experiences. In this way, WHO would be able to advocate equity and solidarity to governments in the alleviation of poverty. Furthermore, it could convince other partners such as the World Bank and the United Nations Development Programme, as well as civil society, that its leadership in the achievement of health for all was paramount.

Dr Brundtland spoke about the proposed changes in budget allocations, the consequences of which she had already discussed with the Regional Director. The work of the Secretariat in determining the new allocation scheme had been solid, fair and well done. There could be no doubt about the need for more resources in the African Region, and one region could gain only at the expense of another. The only way out of this dilemma was indirect, by mobilizing more extrabudgetary resources. However, more could also be done to look at funding as a totality and how this would relate to priorities from a global perspective. It was more difficult to set priorities for the use of extrabudgetary funding, as there were often conditions attached to such funding. However, good work by the Organization would help strengthen its claims to set priorities, even for use of external funds.

The Director-General expressed her solidarity with the Republic of Yemen and the other Least Developed Countries, saying that priorities set at global and regional levels should enable targeting of such countries in spite of budget cuts.

Referring specifically to the increased budget for the European Region, Dr Brundtland noted that that region included the countries of the former Soviet Union and eastern Europe. Health conditions in these countries were worse than previously thought, and in some cases had deteriorated since the end of the cold war. She reassured the Committee that the methodology used by the headquarters team that worked on reallocating the budget was sound, and the change offered an opportunity for more work, carried out more efficiently.

Dr Brundtland noted that the TRIPS Agreement had been negotiated when she was Prime Minister of Norway. The Norwegian Government, and indeed the governments of the Nordic countries as a whole, had gone to great lengths to consult as broad a spectrum of opinions as possible to establish national and regional positions. However, in other regions, ministries of health of many negotiating countries had not been involved in consultations before the WTO Agreements were signed. Thus if a State Party had signed the Agreements without considering their health implications, it was that State's government's fault. However, public health and general interests related to TRIPS had still to be pursued by the Executive Board, and a meeting in October 1998 had been convened to address these issues. Drug policy, pricing policy and availability, among other subjects, were an important part of the attainment of health for all.

In conclusion, the Director-General commended the Jordanian call for balance between WHO's normative function and its capacity-building activities. In response to the comment made by H.E. the Sudanese Minister of Health she hinted that she had said "Sudan", stating that it was the spoken word that counted in all languages. She thanked all the Member States for their valuable comments.

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 1997

Agenda item 4, Document EM/RC45/2, Resolution EM/RC45/R.1

Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean, presented his annual report on the work of WHO in the Eastern Mediterranean Region, stating that as most countries of the Region were going through a process of health sector reform aimed at adapting to new changes and challenges, particular interest was being paid by the Regional Office to capacity-building in the areas of health policy, strategic planning and management, health legislation, bioethics and health economics. He noted that there was a clear shortage of health economics specialists in the Region, and that he would spare no effort to find means to remedy this shortage. He sought support from the Member States in this respect, particularly by approving the transfer of a part of the percentage they allocate to the Regional Centre for Environmental Health Activities (CEHA) to be used for supporting health economics, as CEHA receives an increasing amount of extrabudgetary resources.

The Regional Director emphasized that in recent years considerable evidence had been collected around the world showing that, however many resources existed and however much will there was, sustainable development could not be achieved without the participation of all members of society. One aspect made clear by such evidence had been the recognition of the need to ensure gender equality in decision-making. An example of this lay in the fact that schistosomiasis continued to infect children in some countries of the Region, in spite of the fact that the authorities were providing access to clean water to all houses. This was because water canals, which swarmed with schistosomiasis miracidia, were still considered a daily social gathering place for women, accompanied by their children. Unless this situation, which related to the social dimension of the female sex, was addressed by providing a suitable alternative place for the gathering of village women, then the health problem would continue and escalate. However, the significance of the social dimension of gender was not limited to such examples. There was also the significance of the social dimension in the role of both sexes in development in general, and in health development, in particular. He stressed, in this context, that the principle of gender equality was deeply rooted in the culture, norms and values of this Region.

The Regional Director then touched upon another area of the health system that was of increasing concern in the Region, namely, the provision of health services in emergencies. He said that the past year had seen the exchange of experiences between a number of countries in emergency preparedness and humanitarian action. November 1997 had also seen the inauguration in Tunis of the Mediterranean Centre for Vulnerability Reduction, which had been created to serve as a region-wide technical institution and centre of reference for the whole Mediterranean basin. Its primary concern was to develop the technical approaches and programmes needed to help communities at risk to strengthen their own capacity for vulnerability reduction and risk management. The Centre would undertake health research and multisectoral studies on different aspects of vulnerability reduction at the community level within the framework of sustainable human development. It would also

be a centre for human resource development and for promotion of vulnerability reduction. He commended the activities of the Centre as an important contribution to reducing vulnerability in our Region and invited all Member States to support this new centre in carrying out its huge tasks.

In the area of health protection and promotion, he commended the very successful Nations for Mental Health event at the Forty-fourth Session of the Regional Committee. Combating micronutrient deficiency, he said, continued to be a priority in the Region and emphasized the fact that fortification of flour with iron was gaining momentum. This strategy was particularly suited to the Region because bread and other wheat products were consumed widely. An important and very successful workshop had been held recently in Beirut on fortification of flour with micronutrients at which participants had developed national action plans for the next 12 months to combat iron deficiency. Also at that workshop, flour fortification was seen in practice at a factory. During the Session, he said, samples of iron-fortified bread would be provided for the delegates to try, and he hoped they would find it palatable.

Reminding participants that safe motherhood had been the theme of World Health Day for 1998, he told the participants that progress had been made, to the extent that some countries of the Region had reduced maternal mortality to levels comparable with the best rates in the world. He called for cooperation in the future to try to ensure more accurate mortality estimates, taking into account specific national circumstances, so that this important issue could be more effectively addressed.

There was, he added, another aspect of health protection and promotion: that of healthy lifestyles. While considerable achievements and encouraging successes were being realized in the fight against communicable diseases, countries were witnessing changing demographic, socioeconomic and epidemiological trends. The changes were associated with a rapidly rising prevalence of chronic noncommunicable diseases and a huge public health burden. Accordingly, there was unanimous agreement among health authorities in Member States on the need to initiate effective programmes to prevent and control these rapidly emerging health problems.

He then referred to the birth of some very promising initiatives taken by some countries in establishing community-based projects for the primary prevention of noncommunicable diseases.

Dealing with the problem of smoking, the Regional Director commended Saudi Arabia which, in addition to its ban on advertising of tobacco products in local newspapers and magazines, had banned such advertising in newspapers aimed at young people that were printed externally. That was a positive step, he said, and he hoped it would be followed by a complete ban on all the various types of propaganda which had been creeping into papers and magazines printed abroad, as a way of getting round the ban imposed upon advertising in the local media. He urged those countries that had not yet taken this step to do so. He expressed sadness at the attitude adopted by one particular government in the Region which had refused to continue parliamentary discussions on legislation banning promotional

advertising in the media of cigarettes and other tobacco products, and forbidding the sale of cigarettes to people under 18. That government had argued that such legislation would harm the national economy, in spite of the huge amounts it spent on the treatment of diseases caused by smoking, as well as economic loss due to absence from work and decrease in productivity, not to mention the ethical responsibility of each state for the health of its people. This, he said, was a positive step which he hoped would be followed by a complete ban on all the various types of propaganda which had been creeping into papers and magazines printed abroad, as a way of getting round the ban imposed upon advertising in the local media. He expressed his appreciation of the decision of the Director-General to launch the Tobacco Free Initiative under her direct supervision, noting that the Regional Office would host a meeting of all WHO regions, as well as headquarters, to develop an integrated plan for this initiative for the year 1999 and beyond. He warmly praised the anti-smoking efforts of Lebanon as expressed in the speech of H.E. the President.

He added that the Regional Office, in collaboration with the Islamic Organization for Medical Sciences and the Islamic Educational, Scientific and Cultural Organization, had organized two important meetings in Istanbul. The first meeting had been a conference on "narcotics, psychotropic drugs and smoking: hazards to the new generations", and the other had been a regional consultation for developing guidelines for adolescent health education within the framework of the cultural and religious norms of the Eastern Mediterranean Region. The conference had issued important recommendations on confronting the spread of drug abuse, including smoking, in the countries of the Region. The consultation had adopted a number of amendments which had been introduced into the guidelines, so as to best meet the proper health education needs of adolescent males and females in the Region. It was hoped, he continued, that these guidelines would be issued by the three organizations in the form of three books: one for parents and educators, the second for female adolescents and the third for male adolescents.

Turning to the subject of health systems and services development the Regional Director stated that preparations were being made for a meeting to discuss, for the first time, the idea of accreditation of health care facilities; that is, official recognition of meeting standard requirements, in particular requirements for primary health care facilities.

The Regional Office was embarking upon a major initiative to evaluate medical education programmes, and Dr Gezairy expressed his wish that this initiative would pave the way for the development, in collaboration with the World Federation of Medical Education, of a voluntary system of accreditation of undergraduate educational programmes for health workers. He added that a recent consultation had been held in the Regional Office on private medical education. It made specific recommendations on prerequisites, standards, evaluation, accreditation and monitoring of private medical schools. He expressed his firm belief that it was not possible to establish a medical school on mere profit-making lines. It must be closely linked with the community it served and from which it drew its training resources. It needed to be supported by research facilities and by proper scientific and sociocultural expertise. It must be subject to independent accreditation and inspection. Above all it must fit in with the overall national human resources development plan; if the

existing medical schools were already producing sufficient graduates who met the necessary standards then what justification was there for additional educational facilities?

Addressing the issue of the fellowships programme the Regional Director reminded countries that all fellows were required, on completion of their fellowships, to present a final report, while ministries of health should also provide an annual utilization report on fellows one year after their return home. He said that such reports were important for evaluation of both the effectiveness of such fellowships in the development of human resources for health and the outcome of the programme as a whole. He urged, in this context, the establishment of guidelines for the awarding of WHO fellowships for human resources training.

He then took up the leadership development programme, expressing his satisfaction that it was now approaching institutionalization in the Region. He said that as these programmes had been designed to be self-sustaining he had decided to ask the Joint Programme Review Missions to stop, as of next biennium, deducting from country budgets the percentage that had been previously allocated to the health leadership development programme.

Nursing was another important area of human resources development in the Region. He said that he was pleased to point to the recent publication of guidelines on future directions for nursing education in the Region. He said he had been pleased to take part recently in the graduation ceremony for the first batch of graduates from the Faculty of Nursing at Tishreen University in the Syrian Arab Republic. The Regional Office was very proud of having provided this faculty with its best support.

Also, he continued, the provision of essential drugs had become a cornerstone of health systems development in our Region, and the Regional Office was now focusing on working with countries to develop comprehensive national drug policies, and on strengthening national capabilities in quality assurance and local production of drugs.

The *Eastern Mediterranean health journal* had gone from strength to strength. It was an important forum, and indeed a standard, for discussion of health issues in the Region. The Regional Director mentioned a number of other Regional Office publications published in Arabic, English and Urdu.

In the area of environmental health, he added, an important development in the Region had been the adoption by the Ministerial Conference on Health, Environment and Development in December 1997 of the Plan of Action for Health and Environment in the Eastern Mediterranean Region.

He emphasized that the programme for the promotion of healthy cities, villages and communities in the Region was expanding rapidly, and currently more than 40 cities formed part of the regional healthy cities network. This programme, he noted, was also supported by a number of organizations. He added that despite the increasing awareness in the Region of the valuable resource represented by the environment and of its importance to physical, mental, social and spiritual health and well-being, pollution continued to receive relatively

low attention in our development priorities. He warned against the pumping of sewage into the sea and the dumping of waste, both solid and liquid, toxic and non-toxic, in it. He urged all countries of the Region to maintain vigilance, with regard to their own actions as well as those of others, that may be harmful to the environment. Only recently, a neighbour of the Region had dumped 60 tonnes of toxic waste into the Mediterranean, endangering not only the beaches of its neighbours but the health of all the Mediterranean basin, known to be among the most fragile and endangered of environments.

The Regional Director noted the steady progress that continued in the fight to eradicate and eliminate specific diseases. It remained essential to pay great attention to strengthening of surveillance of acute flaccid paralysis.

He stressed the importance of rapid exchange of accurate and comprehensive information between Member States, and said that the epidemiological bulletin on poliomyelitis, *Polio fax*, would henceforth be issued weekly instead of monthly. It had also been decided that reporting of acute flaccid paralysis cases should be developed in such a way that data on each case should be shown separately (line listed), and that detected viruses should be reported to WHO so their transmission could be followed up within the Region, and necessary measures taken to tackle and destroy them.

With regard to elimination of measles and neonatal tetanus, he said that efforts were needed to increase the levels of coverage of measles vaccination among children and of tetanus toxoid among women of childbearing age with the aim of reducing mortality due to these diseases. Measles surveillance, he added, was still lacking.

Referring to tuberculosis, the Regional Director stated that the Region had responded enthusiastically to the directly observed treatment, short course, or DOTS, campaign against it.

As regards malaria, Dr Gezairy said that efforts were continuing in strengthening malaria control in those countries where it represented a serious problem, adding that hopes were now pinned on the success of the Roll Back Malaria initiative. This was a high priority of the Director-General, and he promised the Region would work with her until the whole world was rid of that terrible disease.

The Regional Director referred to the situation with regard to HIV and AIDS, saying that they continued to be monitored and controlled. While prevalence was relatively stable compared with other regions, the Region must continue to be vigilant and to guard against complacency.

He said that the joint WHO/UNICEF initiative on integrated management of childhood illness, aimed at reducing major morbidity and mortality among young children in the most cost-efficient and effective way, had been launched early on in Egypt, Morocco and Sudan and then in the Islamic Republic of Iran, Pakistan and the Republic of Yemen. The initiative would be gradually extended to other countries.

Endemic diseases and tropical diseases, he continued, still posed a major problem for many countries in the Region. He added that just as the Region had celebrated, two years previously, the eradication of guinea-worm disease in Pakistan, it was hoped that we would be able to celebrate eradication soon in the Republic of Yemen. He also hoped that Sudan would receive all the financial and technical assistance necessary from the international agencies supporting the eradication of this disease.

Dr Gezairy stated that the World Health Assembly next year would consider several amendments to the Constitution of the Organization. It was his duty, he said, to remind participants in the Regional Committee meeting that such amendments could not be effected without the formal ratification of the governments, as represented by the head of state or the ministry of foreign affairs, of two-thirds of the Member States, and he asked all Member States who had not yet done so to send their ratification of this amendment as soon as possible through their ministries of foreign affairs.

Dr Gezairy concluded by informing the Committee that the building contract for the new Regional Office in Cairo had been signed and construction work had started. He expressed hope that the Forty-seventh Session of the Regional Committee would be held in the year 2000 in the new Regional Office.

Discussions

H.E. the Minister of Public Health of Tunisia commended the Regional Director's report and the wealth of information included therein, particularly on issues such as the Basic Development Needs approach, the development of quality assurance systems and information exchange. He mentioned the Tunisian experience in establishing the national solidarity fund, based on voluntary contributions, to support development projects, mainly in underserved areas. He requested that more attention be devoted to new health challenges and to women's health, and reiterated the call for increased attention to issues of prevention of disease and bulk purchase of drugs.

H.E. the Minister of Health of Bahrain commended the report and the efforts made in the Regional Office to strengthen statistical data systems; issue Arabic/English translations and publications in primary health care; support rational use and quality assurance of drugs; support fellowships; and strengthen disease prevention and control. He further noted with appreciation the efforts of the Regional Office in resource mobilization, raising extrabudgetary funds, encouraging revision of national health legislation, issuing medical textbooks in national languages and use of advanced technology in publishing.

H.E. the Minister of Health of the Syrian Arab Republic requested the Regional Director to take up with WHO headquarters the issue of the budget reduction applied to the Region and the technical issues relating to distribution of extrabudgetary resources. He also spoke about the vagueness and risks sometimes involved in drug use and called for transparency and clear information and guidance in this respect. He spoke about the issue of disease prevention and safety of vaccines, and mentioned that many countries of the Region had problems relating to vaccine safety; some of these problems might be real, while others

might be groundless. He added that his country had repeatedly requested WHO headquarters to provide clarifications in this connection, but so far no satisfactory reply had been received. He also requested the Regional Director to discuss with headquarters the issue of giving hepatitis B vaccine to all children and the possibility that it might cause multiple sclerosis and to inform countries of the outcome accordingly*.

The Representative of Oman spoke about the problem of private medical education and the increasing number of medical graduates who were not well prepared. He also spoke about the hazards of smoking and hence the need to combat it, in particular through use of the media to convince the public to abstain. He emphasized also the importance of health economics and micronutrients.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran called for national health-related and biomedical information capabilities to be strengthened. All ministries of health should develop websites to allow as broad access to information as possible. Community involvement was an important part of the achievement of health for all but not enough of the community was as yet mobilized. The Iranian women health volunteers programme was successful and could be expanded to other groups. Basic development needs and healthy cities and *wilayat* activities were other examples of intersectoral collaboration, and more such collaboration was needed. The Minister said that pilot projects were not enough and should be expanded. More expertise and regional standards were needed to improve the quality of health services. Food and nutrition—basic development needs—were priorities given the prevalence of under-5 malnutrition, especially in the Least Developed Countries.

With respect to communicable diseases, the Minister said that more needed to be done to address emerging and re-emerging diseases such as HIV/AIDS, tuberculosis and malaria, although progress reports from the Region were encouraging. He proposed the creation of multinational committees that would meet regularly to confront diseases prevalent in cross-border areas. Maternal and neonatal mortality still called for more effort: in the Islamic Republic of Iran, committees had been set up at national and regional levels for this purpose. The Minister commended the integrated management of childhood illness initiative.

The Representative of Jordan, with respect to the WHO reforms, called for evaluation of the primary health care initiative 20 years after the Alma-Ata Declaration, suggesting that primary health care as practised had become too rigid. As headquarters preached global equity, so should the Region have regional equity. The shifting of resources from one programme to another, such as from CEHA to health economics, should stem from a clear vision of priorities since meeting people's health needs, especially in the Least Developed Countries in the Region, was more important than training courses. Hence, a new approach

* A WHO circular disproving any relationship between viral hepatitis B vaccine and multiple sclerosis was circulated the following day.

to setting priorities was needed. More equity could be achieved through more relevant programmes.

H.E. the Minister of Public Health of Morocco stressed the importance of maternal health and its link to the philosophy of the Basic Development Needs approach. He said that in Morocco only one experiment had been conducted, and that had proved feasible. This experiment would therefore be extended to other areas. He also pointed to the importance of immunization and requested WHO to dispel the suspicions surrounding this subject.

The Regional Director thanked the representatives of Member States who commended the work of WHO in the Region and stressed that the Regional Office and Member States were partners in the success achieved.

He emphasized that both the primary health care and basic development needs programmes required community involvement and intersectoral cooperation, the aim being to improve health conditions, raise the standard of living and alleviate poverty. By way of example he pointed out that in one of the villages of Pakistan immunization coverage had risen from 13% to 90% within one year only due to the success of confidence-building between the community and health services. He commended the bulk purchase of drugs which had been successfully applied in the countries of the Gulf Cooperation Council and would soon be applied in the Maghrebi countries, and noted that such purchases had resulted in drug-cost reduction and better drug quality.

The Regional Director said that the safe motherhood programme aimed at reducing maternal mortality. He pointed out that female literacy and ensuring the availability of at least one midwife in every village would lead to a reduction in the rates of maternal mortality and neonatal tetanus. He commended the development of nursing and midwifery, particularly in Bahrain.

He expressed hope that the Regional Office would in due course discuss with WHO headquarters the points raised by countries of the Region and that the presence of the Director-General in the present meeting would enable her to form a realistic idea of the needs and problems of the Region.

As regards vaccines, he emphasized the importance of ensuring safety and quality assurance. With respect to smoking, he stressed the importance of various control efforts, intersectoral cooperation, and halting all types of tobacco promotion.

Commenting on private medical education, the Regional Director said that it was essential to discourage the current trend in the Region of establishing low-standard medical colleges. He commended the successful Iranian model of one unified ministry for health and medical education, which enabled the Minister to give proper orientation to medical education.

Dr Gezairy said that there were multinational committees for disease control in border areas, such as those concerned with malaria control on the Egyptian and Sudanese borders, and that concerned with tuberculosis control in the Horn of Africa.

Statement by representatives of organizations

Statement by His Royal Highness, Prince Abdel Aziz Ahmed Bin Ahmed Bin Abdel Aziz Al Saud

His Royal Highness, Prince Abdel Aziz Ahmed Bin Ahmed Bin Abdel Aziz Al Saud, Chairman of the Board of Directors of IMPACT, outlined some of the activities of IMPACT, and referred to the proposal he had submitted in 1993 during the Forty-first Session of the Eastern Mediterranean Regional Committee with regard to organizing a programme to address the backlog of cataract cases in the Eastern Mediterranean Region. That proposal had been the beginning of the IMPACT cataract control programme, in addition to other programmes implemented in collaboration with the Regional Office for the Eastern Mediterranean, ministries of health and nongovernmental organizations.

In the Republic of Yemen, IMPACT had established, in collaboration with the Regional Office, a programme to train Yemeni physicians in cataract surgery. The first batch had already graduated and the second batch would soon graduate also. During their training, these physicians had performed more than 800 cataract surgeries.

In Sudan IMPACT had established, in collaboration with Al-Nur Charitable Society, a therapeutic camp where 3529 eye patients were examined; 76% of the patients were below the age of 60 and 24% were over 60. Cataract surgery was carried out on 9% of these patients, glaucoma surgery on 2.5%, eyelid surgery on 1% and other surgery on 3.5%. Treatment was provided to other patients where cases did not require surgical intervention.

In Djibouti, IMPACT, in collaboration with Al-Nur Charitable Society, examined 468 patients, carried out surgery on 11% of them, and treated the rest. In Lebanon, a collaborative programme with the Ministry of Public Health had been initiated to reduce the backlog of cataract cases, while in Bahrain a comprehensive survey to investigate causes of poor eyesight had been conducted on schoolchildren, who were then treated as needed.

His Royal Highness emphasized the importance of the work undertaken to eliminate the backlog of cataract cases within 10 years, of which more than four years had now elapsed. He called upon WHO to urge governments and nongovernmental organizations to eliminate the backlog of cataract cases as soon as possible, and expressed hope that this task would be fulfilled before 2003. He also urged WHO to give due attention to training programmes for physicians in performing cataract surgery.

In conclusion, he wished the Regional Committee every success, and positive health achievements for Eastern Mediterranean Region populations.

Statement by the Representative of ISESCO

Ms Asmaa Mohammed Abdallah, Representative of the Islamic Educational, Scientific and Cultural Organization (ISESCO) at the Forty-fifth Session of the WHO Regional Committee for the Eastern Mediterranean, delivered a statement in which she mentioned that ISESCO was established by a resolution adopted by the Islamic Summit held in Mecca in 1981. She enumerated the objectives of ISESCO, and the activities carried out by it for implementing those objectives.

She pointed out that ISESCO, believing in the importance of cooperation with international, regional and national organizations and institutions with common interests, established close cooperation with several organizations in the United Nations system, including UNESCO and WHO, as well as several regional organizations, such as the Arab League Educational, Cultural and Scientific Organization, and concluded numerous cooperation agreements with them.

Mrs Abdallah mentioned that cooperation between ISESCO and the Regional Office dated back to 1989, noting that cooperation was much strengthened by the fact that 20 of the 23 Member States of the Region were members of ISESCO. This cooperation included, *inter alia*, conducting training courses, participation in symposia and organization of meetings.

Statement by the Representative of the Organization of African Unity

Ambassador Ahmed Haggag, Assistant Secretary-General, Education, Science, Culture and Social Affairs Department, Organization of African Unity, noted that decisions taken in the Regional Committee for the Eastern Mediterranean affected OAU members too as many Member States were also members of the OAU or bordered them. Africa had a major AIDS problem, and could learn much from Eastern Mediterranean Region culture, experiences and programmes. The same was true of malaria. He noted that there was insufficient information about what other regions were doing, especially in response to the perceived constraints that the World Trade Organization agreements would impose, and called for cooperation between WHO, OAU, Group of 77, Nonaligned Movement and others, taking advantage of WHO's presence in the OAU/ECA offices in Addis Ababa, Ethiopia, as a link.

3.2 Report of the Regional Consultative Committee (twenty-second meeting)

Agenda item 7, Document EM/RC45/5, Resolution EM/RC45/R.8

Dr Anne Marie Worning, Regional Adviser, WHO Programme Development, presented the report of the twenty-second meeting of the Regional Consultative Committee (RCC), held in Amman, Jordan, from 2 to 3 May 1998. The agenda comprised the following items:

1. Follow-up of the implementation of the recommendations of the twenty-first meeting;
2. Health in border areas;
3. a) Regional allocations;

- b) Advocacy and resource mobilization;
- 4. The private sector and the national health system;
- 5. Continuing education as an integral part of health care development systems;
- 6. Mental health;
- 7. Subjects for discussion at the twenty-third meeting of the Regional Consultative Committee and the Forty-sixth Session of the Regional Committee in 1999;
- 8. Other matters.

Dr Worning said that health-care policy and strategy had been a common theme throughout the opening remarks made by the Chairman, Professor Mamdouh Gabr, H.E. Dr Ashraf Kurdi, Jordanian Minister of Health and Health Care and Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. Dr Kurdi described the health strategy that had been developed for Jordan for the next 12 years and in this respect noted the importance of continuing education. Strengthened professional performance was an essential part of developing a health care system that provided cost-effective and high-quality services.

In his introduction Dr Gezairy focused on the revised WHO strategy of health for all in the 21st century and pointed to the achievement of WHO in changing the perception of health from being the mere absence of disease to a concept of complete physical, mental, social and spiritual well-being. He emphasized the Regional Office's participation in the development of the revised strategy and was especially happy that the spiritual dimension was now included.

As regards item 1, on the follow-up of previous recommendations, Dr Worning said that the RCC had expressed overall satisfaction with the progress made in implementing these. In view of the nature of some of the recommendations it was positive that the overview of progress had not been limited to the recommendations of the previous year. This trend should be further strengthened and this agenda item given even more attention in future Sessions. Constraints and difficulties in implementing the recommendations should be critically analysed in order for the RCC to suggest solutions and also to give a clearer picture of the effectiveness of the Committee.

As regards item 2 on health in border areas, it was noted that there was a global lack of basic information and accurate health statistics, and the Committee recommended that effort be put into improving this situation. A regional focal point should be appointed and other agencies both within and outside the UN system should be consulted in this process. A comprehensive initiative on health and development in borderlands should build on already ongoing regional communicable disease control activities, especially those of the malaria programme.

Item 3, concerned with regional allocations, led to a very long and detailed discussion, and the magnitude of the proposed cut for the Eastern Mediterranean Region was a cause of great concern. The Committee suggested that alternative ways to explore to finance the increased allocations of the African and European regions without reducing the budgets of the other four regions in the way suggested by the mathematical model. Countries of the

Region were also urged to intervene in a forceful and concerted manner at the World Health Assembly immediately following the session of the RCC.

Item 4 dealt with advocacy and resource mobilization. The Committee noted that in-depth experience in resource mobilization was lacking in the Regional Office and that extrabudgetary funds received were for that largest part for emergency situations. The Committee recommended that the Regional Office strengthen its efforts to mobilize resources with a variety of innovative mechanisms, while taking advantage of specific Islamic benevolent practices.

Item 5 was concerned with the role of the private sector in the national health system. The Committee in its discussion recognized that most countries in the Region are at different stages of health sector reform. The level of privatization ranges from minimal to the private sector's being the main provider of health services. Several countries of the Region had experienced different types of market failure, illustrating the need for a strong ministry of health to design and regulate the health sector. The Committee recommended that governments be responsible for the health of the nation while the delivery of health care services might be a responsibility shared between the state and the private sector. In developing the private sector emphasis should be on achieving national objectives and particularly improving the health of the poor and vulnerable. To assist countries in ongoing health sector reform, the Regional Office should develop a programme that will provide technical support to countries in establishing the appropriate private/public mix.

Item 6 concerned continuing education as an integral part of health care development systems. The Committee recognized the importance of continuing education programmes in ensuring cost-effectiveness of health care services and raised the issue of the role of the government in managing these. The Committee recommended that continuing education programmes be institutionalized as an integral part of the national health system and that the implementation of these should be a joint responsibility of the ministry of health, professional societies and scientific associations. The feasibility of developing a voluntary incentive-motivated system of re-accreditation should be explored.

Item 7 referred to mental health. The importance of mental health in the future was clear and the need to integrate mentally ill patients into community life was stressed by the Committee. The experience of the countries of the Region over the past 15 years has shown that integration is possible and is a targetable and affordable action in the area of mental health. The awareness of ministers of health of this issue had been raised during a combined Regional Office and headquarters mental health event held in connection with the Regional Committee in the Islamic Republic of Iran in 1997. The Committee urged countries of the Region to implement the 10-point programme that was a result of this initiative. Countries of the Region should place increased emphasis on developing and/or updating mental health legislation. The Regional Office should collect information on the use of psychiatric medication in the countries of the Region and following this conduct a consultation on the safe use of these medications. By combined efforts the Regional Office and countries of the Region should strengthen efforts in early detection and prevention of mental illnesses

through collaborating with other community programmes such as school health, maternal and child health, and healthy cities.

Item 8 dealt with the subjects for discussion at the twenty-third meeting of the Regional Consultative Committee and Forty-sixth Session of the Regional Committee. The RCC respected the decision taken at one of its earlier meetings to draw up a prioritized list of potential subjects and put this list forward to the Regional Committee with the understanding that one topic would be chosen from each of the following four categories: health policy and management; health systems and services development; promotion and protection of health; and disease prevention and control. This will be considered as a separate agenda item during this Session of the Regional Committee.

In other matters, the Committee endorsed the draft statutes of the Down Syndrome Research Prize Foundation in the Eastern Mediterranean Region.

Discussions

The Representative of the Libyan Arab Jamahiriya praised the efforts of the Regional Consultative Committee saying that he wished to focus in his comments on the subject of continuing education. He requested the Regional Office to introduce a page on the Internet for research.

The Representative of the Islamic Republic of Iran said that the Regional Consultative Committee had addressed some critical issues and made valuable recommendations. Referring in particular to the experience of the Islamic Republic of Iran in continuing education for health personnel, he noted that this occupied a priority position in the health management system. In the Islamic Republic of Iran continuing education had been institutionalized through an act requiring all health professionals to apply for relicensing every five years, the aim being to promote knowledge and skills and so maintain quality in health service delivery. Continuing education programmes covered all levels of health personnel and involved all the medical sciences bodies concerned in addition to the Ministry of Health and Medical Education. Emphasis was now being placed on evaluation and research to improve quality in continuing education.

The Representative of Sudan referred to the subject of health in the border areas, and called for the establishment of collaborative and coordinating activities between the Eastern Mediterranean Region and the African region, in order to control diseases in the border areas between his country and neighbouring countries. He added that it was possible for AIDS to spread into Sudan through the borders.

The Representative of Pakistan noted with appreciation the useful work done by the Regional Consultative Committee in prioritizing issues. He said that Pakistan was already working on strengthening health policy, taking into account health economics and the role of the private sector. Emphasis was placed on development of human resources and strengthening of primary health care. Health education was also stressed through collaboration with the mass media. He proposed that this be a subject of future Regional

Consultative Committee discussions in order to work towards a regional health education policy and strategy.

The Representative of Saudi Arabia indicated that all the subjects discussed by the Regional Consultative Committee were important, and that if every Member was to mention its achievements, in the various fields, more time would be necessary. What was needed, in his opinion, was collaboration and coordination between the Member States on the one hand, and between countries and the Regional Office on the other, in all fields.

4. BUDGETARY AND PROGRAMME MATTERS

4.1 Proposed programme budget for the Eastern Mediterranean for the financial period 2000–2001

Agenda item 5, Document EM/RC45/3, Resolution EM/RC45/R.2

This item was presented by Mr T.H. Mirza, Director, Administration and Finance. It was prepared in consultation with Member States and in accordance with the Ninth General Programme of Work covering the period 1996–2001 and priorities identified by Member States. The Ninth General Programme of Work outlined four main policy orientations: 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 programme areas described in the budget along with two other areas: governing bodies and administrative services. At the next level of detail in the programme budget came the 19 major subprogrammes at the so-called two-digit level considered appropriate for strategic budgeting.

Mr Mirza said that the 2000–2001 regular budget had initially been developed at the same dollar level as that of the biennium 1998–1999, i.e. US\$ 90 249 000. This level had been communicated in November 1997 by the Director-General as an initial planning figure. Following the adoption of resolution WHA51.31, the Director-General had notified the Regional Director that the Eastern Mediterranean Region budget level would be US\$ 85 869 000, which was US\$ 4 380 000 lower than the previously communicated level.

Careful consideration had been given to the areas of the budget where this reduction was to be applied. The critical factor in the decision was that the Organization had already absorbed several reductions in recent biennia. The WHO budget level for 1996–1997 had been reduced by 13% in real terms. In addition, programme budget implementation reductions totalling 5.5% had been made in the biennia 1996–1997 and 1998–1999. As a result, the Regional Office and interregional budgets had already absorbed the maximum amount of budget cuts. Any further reductions would be counterproductive and could lead to a serious loss of management control and inadequate support to programmes of Member States. Mr Mirza also pointed out that the intercountry programme represented some 17% of the total regional regular budget resources and was directed primarily towards supporting country programmes. It had therefore been decided that the budget reduction of US\$ 4 380 000 would be applied as a first step towards the eventual alignment of country allocations to the human development index (HDI) model. He emphasized that, after adjustment for the regional reallocation, the country allocations in the regional proposed programme budget for 2000–2001 represented 64% of regular budget resources. This was one of the highest ratios among all WHO regions. He added that the subject of regional allocations would be discussed later under agenda item 6(a).

Mr Mirza highlighted some of the major points of the programme budget as follows.

- Once the regional reallocation had been fully implemented over the next few years, the regular budget levels would result in the same nominal dollar level as 10 years previously, without taking account of cost increases during the intervening period.
- The regional proposed programme budget for 2000–2001 represented some 10% of the total WHO regular budget and some 15% of the total allocations to all regions.
- The regional proposed programme budget for 2000–2001 consisted of country (64%), regional (19%) and intercountry programme allocations (17%). Thus the country and intercountry programmes accounted for a total of 81% of the budget. The country share in the Eastern Mediterranean Region was among the highest in all the regions of WHO.
- The distribution of the proposed regular budget to programme areas was:

	US\$ millions
Health services development	29.5
Health policy and management	25.6
Promotion and protection of health	12.3
Integrated control of diseases	12.2
Administrative services	6.1
Governing bodies	0.2
	85.9

- The level of extrabudgetary funds in the Eastern Mediterranean Region had declined substantially in recent biennia compared with the biennium 1994–1995, due principally to a transfer of the Global Programme on AIDS to UNAIDS, but due also to a drop in funds from UNDP and UNFPA.
- With the exception of the Region for the Americas (if the funds of PAHO were excluded), the extrabudgetary resources of the Eastern Mediterranean Region were the lowest among the regions.
- Administrative services represented 7.37% of the total budget from all sources and this was also among the lowest ratios in the regions.

Mr Mirza concluded by saying that the budget outlook was bleak inasmuch as there would eventually be a cut of 14% in regular budget resources of the Eastern Mediterranean Region. This would bring the budget to the level of 10 years previously, without taking account of inflation during the intervening period. This outlook was against a background which indicated the possibility of an economic slump in certain countries. This made it difficult for countries to allocate additional resources to health. However, the Region faced many health challenges and consideration should be given to ways and means to supplement

current funding by voluntary contributions to counter the decrease in real terms of regular budget resources available to the Region. He regretted the delay in submission of the programme budget and added that Member States would have an opportunity to reprogramme country allocations prior to implementation following the Joint Government/WHO Programme Review Missions which were planned for the second half of 1999.

4.2 Regional allocations

Agenda item 6(a), Document EM/RC45/4(a)

The item was presented by Mr T.H. Mirza, Director, Administration and Finance. He said that in January 1997 the Executive Board had requested a review of the basis for allocation of regular budget resources to regions, and its possible modification using the fundamental principle of equity and support to countries in greatest need. The Forty-fourth Session of the Eastern Mediterranean Regional Committee had questioned the need for a mathematical model since, under the Constitution, it was the Director-General's prerogative to decide on such allocations. Nevertheless the Committee had felt that, if such a model were to be adopted by the governing bodies, it should be based on authoritative data, be responsive to changes, take into account extrabudgetary funds, be equitable to countries and regions and not result in allocation reductions as a result of positive achievements.

In January 1998, the Executive Board had reviewed the matter in detail and recommended a resolution for possible adoption by the Fifty-first World Health Assembly proposing a mathematical model based on the UNDP Human Development Index (HDI) to be introduced with effect from the biennium 2000–2001.

Mr Mirza said that in May 1998, immediately prior to the World Health Assembly session, the Regional Consultative Committee of the Eastern Mediterranean had reviewed that resolution and its impact on the Eastern Mediterranean Region in detail. In addition to the criteria recommended earlier by the Forty-fourth Session of the Eastern Mediterranean Regional Committee, the Regional Consultative Committee felt that the first application of the resolution should be deferred to the biennium 2002–2003, that a special weighting should be applied in favour of the Least Developed Countries, and that the imbalance of allocations between regions (as suggested by the HDI) should be corrected, to the extent possible, by adding resources to the African and European regions without reducing the allocations of the other regions. The Committee felt that this should be achieved by using a combination of the resource shifts of 2% per biennium mandated by resolution WHA48.26, by efficiency savings and cost reductions at headquarters, and by casual income expected to be available in future biennia.

Mr Mirza noted that in the first week of consideration of this subject by the Fifty-first World Health Assembly, there had been considerable divergence of opinion on this subject and a special working group had been established to determine common ground. After several private sessions, the group had submitted a draft resolution which was finally adopted in resolution WHA51.31 on the last day of the meeting.

The long-term impact of the resolution, based on the 1998–1999 budget, was that eventually the transfer of resources totalling US\$ 105 million would be made from four regions for the benefit of the African and European regions. The Eastern Mediterranean Region would receive a reduction of some US\$ 13 million, representing 14% of its 1998–1999 allocation. As concerns the short-term impact on the budget for 2000–2001, in June 1998 the Director-General had notified the regions that he had decided to increase the allocations of Africa and Europe by US\$ 19.4 million and US\$ 2.2 million respectively, and to reduce that of the Americas by US\$ 5 million, the Eastern Mediterranean by US\$ 4.4 million, South-East Asia by US\$ 3.7 million and the Western Pacific by US\$ 4.4 million. This resource reallocation had necessitated an additional transfer of US\$ 4.2 million from global and interregional sources.

Mr Mirza added that during the presentation of the programme budget document under the previous agenda item, he had already explained the difficulties associated with implementing this decision at such short notice and after the Member States of the Region had already communicated their country programme statements. However, the regional reallocation resolution would have a serious long-term impact, and the reduction in country allocations for 2000–2001 should be seen as the first step towards an eventual realignment of these allocations to the HDI-based figures.

The criteria for recalculation of the regional country planning figures for 2000–2001 to take account of the US\$ 4.4 million budget reduction was as follows.

- As mandated by resolution WHA51.31 there would be no change in allocations for Least Developed Countries (five Members). The allocations for Palestine and Members warranting increases (three Members) were maintained without change since it would be inappropriate to grant increases when most allocations were being reduced drastically.
- A 50% reduction in allocations would be applied for Members for which the HDI model suggested zero allocations (four Members)
- The remaining balance (US\$ 3.3 million) of the total reduction would be borne by the other 10 Members *pro rata* to their HDI-induced reductions.

Mr Mirza added that the World Health Assembly had requested the Director-General to report, *inter alia*, annually to the Executive Board and to the World Health Assembly on possible refinements to the mathematical model.

He invited the views of the Regional Committee on the following principles which had been suggested by the discussions at the Regional Consultative Committee and by the Member States of the Region during the Health Assembly:

- the inclusion in the mathematical model of extrabudgetary resources, which were unevenly distributed among regions, with the African and European regions as the largest recipients;

- increased use of global and interregional shifts in accordance with World Health Assembly resolution WHA48.26, together with efficiencies and relocation of tasks to cheaper locations and use of casual income;
- the introduction in the World Health Assembly formula of the principle that the limit of annual reductions for any region should be expressed as a percentage (say 10% per year) of the perceived imbalance, rather than the previous regional allocation base, in order to introduce proportionality among regions;
- phasing in the reductions on a progressive basis; early biennia being cushioned by transfers from casual income in order to mitigate the immediate impact on country allocations and to avoid unnecessary adjustments when, at a later stage, extrabudgetary sources of income are introduced in the model.

Discussions

The Representative of Lebanon said that the delegates of the Eastern Mediterranean Region Member States had discussed the subject of regional allocations at length in Geneva and made suggestions to reduce the injustice to the Region. The Director-General was in a position to help to this effect. There were scientific indices other than the Human Development Index (HDI) that could have been applied which would have produced different results. He enquired about the possibility of reconsidering the distribution of the regular budget allocations to the Region.

The Representative of Jordan wondered why this matter was being raised given that it had been decided by the Health Assembly at which all the Member States were represented.

H.E. the Minister of Health of Saudi Arabia noted that the Director-General had said the previous day that the regional budget allocations were final. Then, he asked, what was the role of the ministries of health? He also asked whether the Member States should accept the reductions without any discussion.

The Regional Director said that the allocation of the regular budget was the prerogative of the Director-General, who put it forward to the Member States for approval at the World Health Assembly. If approved, the budget would then come into effect. Inclusion of extrabudgetary resources in the distribution formula was also a prerogative of the Director-General. The Regional Director repeated the Director-General's comment from the previous day that she would try to offset some of the cuts in the 2000–2001 biennium from casual income. He noted that the Eastern Mediterranean Region reduction in the coming biennium exceeded that of the South-East Asian Region and that regional secretariat representatives had not been able to participate in the discussions that had taken place in Geneva.

H.E. the Minister of Health of Saudi Arabia hoped that the presence of the Director-General in the present Session of the Regional Committee would help in taking the needs of

the Region into account and enquired how the budget situation in the Region would be improved in future biennia.

H.E. the Minister of Health of the Syrian Arab Republic said that the regular budget allocation to countries would generally amount to less than 0.5% of national expenditure on health services. Moreover WHO support for countries was targeted at programmes advocated by WHO; thus these programmes would be the first to be affected by the reduction in allocation.

The Representative of Jordan called for the use of casual income and extrabudgetary funds to compensate for cuts in the regular budget.

H.E. the Minister of Health and Population of Egypt said that the issue was too complex to be discussed in a simple fashion. While approving the increases to some countries in the Africa Region, there were countries in other regions which suffered from similar problems to those of the African countries, and this fact had not been taken into consideration. It was necessary to study the decision again more objectively. Budget allocations should, he said, be based on new and fair criteria that would satisfy the needs of those countries that had suffered cuts. Some countries suffered from severe problems, such as malaria, and the magnitude of the health risks due to these should therefore be taken into consideration in addition to HDI.

Referring to the non-payment of contributions, the Minister emphasized the need to request those countries concerned to address the issue more positively, especially in light of the new situation with regard to regional allocations.

He welcomed the suggestions made to reduce headquarters costs by moving the activities of some programmes to Alexandria or to other countries. The Egyptian Government was, he said, ready to make the old Regional Office building available for that purpose and there was also another 14 000 m² which could be made available.

Referring to the distribution of the budget within the Region, the Minister considered the division of the countries into four groups for this purpose to be fair, since it addressed the special situations of some Member States.

H.E. the Minister of Health of Cyprus observed that four countries of the Region would receive zero allocation according to the HDI formula. This zero allocation would have two major disadvantages: first, these countries would be forced to terminate all programmes initiated on the basis of the regular budget; and second, maybe more important, these countries would lose the direct contact and guidance they received from the JPRM teams which supported national planning on the basis of both local priorities and WHO policy. Furthermore, zero allocation countries which in addition had no WHO Country Representative's Office would have their direct dealings with WHO limited to participation in the Regional Committee; all other contact would be limited to print and Internet publications and data—assuming there was time to peruse them. The Minister felt that this

was inadequate, and called on the Regional Director to find effective ways for such countries to maintain due contact with WHO.

The Representative of Iraq questioned whether regional representatives had been aware of the conditions prevailing in the Region at the time of the budget reallocation discussions in Geneva, noting that countries of the Region included those suffering embargos, high prevalence of disease and inability to use national resources to improve health services. Since there had been no opportunity for the Region to express its views and needs properly, the subject should be reconsidered. He said that situations arising from the reduction of allocations in the biennia to come after the biennium 2000–2001 should be addressed.

The Representative of Sudan noted that the mathematical model lacked equity, bearing in mind that the Health Assembly resolution emphasized that the Least Developed Countries should not be affected by the budget reductions. He asked the Director-General how she would act to prevent the Least Developed Countries from being affected and how the subject could be reconsidered.

The Regional Director said that when the subject had been discussed by the Health Assembly, neither the principle of equity nor the needs and interests of the regions had received due attention; and some delegates had asked for the subject to be deleted from the agenda. Eastern Mediterranean Region representatives had spent a great deal of time, up until midnight, trying to convince other delegates of the Region's needs and special conditions as well as of the need to distribute budget allocations equitably. He especially noted that the reductions based on HDI would reduce Least Developed Countries' allocations at the same time as the Health Assembly resolution confirmed that they would not be affected. The Regional Office had not had an opportunity to discuss the new allocations with the former Director-General; it was now difficult for Dr Brundtland to change the situation. However, if she were willing to reconsider the matter, the situation concerning the biennia after 2000–2001 might be improved and the Region receive a larger share from the inclusion in the model of extrabudgetary allocations, noting that its present share of such allocations was the lowest among the regions. Dr Gezairy invited the Regional Committee to accept the proposed distribution, hoping that the Director-General would try to alleviate the suffering of the Eastern Mediterranean Region in future biennia.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran said that whatever model was used for allocation of regular budget should be flexible in order to minimize the adverse affects of budget cuts on countries and should not be merely a mechanical process. He observed that many countries were in states of transition; thus a mathematical formula based on a "snapshot" of a country's situation at a given time might not show accurately a country's true position. In addition, such a formula might not be able to reflect a country's *potential* to use funds, should funding be available. He asked for extrabudgetary, interregional and global funds to be taken into consideration when allocating regular budget. In addition, he said, the ability to define priorities lay within countries and was not amenable to a global perspective.

The Representative of Oman said that there had not been enough time to discuss the subject at length during the informal meetings on the last day of the Health Assembly. He did not accept the fact that the Eastern Mediterranean Region's reductions were to be absorbed over six years while the other regions' reductions would be absorbed over 15 years. Equity among regions applied here, too. He also called on the Director-General to reconsider matters and allocate extrabudgetary funding to the Region during the coming biennia to redress the imbalance.

Dr Brundtland replied by saying that it would have been nice to have kept all of the 191 Member States happy, but this was a forlorn hope given the number of issues and conflicting interests involved. She pointed out that this was the first time the Health Assembly had addressed the issue of regular budget reallocation at a global level, and that it took place during her predecessor's tenure as Director-General.

The Director-General identified two main issues that had characterized the discussion and added a third. The first issue was what had happened prior to the Health Assembly. Was the Governing Bodies' decision wise to choose the HDI indices on which to base regular budget allocation? Could the principles they used and the choices they made be questioned? These doubts were understandable as there could be no completely fair model on which to base redistribution. Nevertheless, decisions on this were in fact taken by the Health Assembly.

A second issue, added by Dr Brundtland, was that of evaluation. All involved—the Governing Bodies, the countries, the Director-General herself and everyone else—were obliged to evaluate whether the new system was working and the needs of countries were being adequately and fairly addressed.

The third issue clarified by Dr Brundtland was the use of the regional budget itself in addressing countries' needs. The Health Assembly had decided on the principles of new allocations, and WHO rules must be followed. She could not disburse money that she did not have. To raise the matter of casual and extrabudgetary funding was to distract attention from the main issue. The question in a nutshell was, given the budget allocated to the Region, how could the Region make best use of it. The Director-General stated her position strongly: this was a clear function of the regional committees, as they were closest to the problems in their regions. If the internal allocation of funds was wrong, the matter should be debated in the *regional* committees. She noted that some countries' comments showed that they had understood this. Others however were still concerned with the World Health Assembly resolution—a decision that could not be reversed; and as the decision had been taken in a properly constituted forum, all Member States were obliged to follow up the resolution.

In response to the alleged unfairness of the proposed periods for implementing the new budget levels, which varied by region depending on the percentage cut, Dr Brundtland said that it was not unwise, for example, that a 50% cut should be implemented over a longer period than a 14% cut.

Dr Brundtland also reminded the Committee that the World Health Assembly resolution had been passed prior to the world financial crisis that was affecting many countries. She pointed out that economic problems had hit other regions worse than the Eastern Mediterranean Region.

The Chairman reviewed the discussions, asking that the criteria used to recalculate the allocation be reviewed in order to achieve equity, noting that WHO could adopt innovative approaches and programmes. He acknowledged that country allocations represented a very small percentage of national health expenditure. However, the said allocations received attention from Member States since WHO was their partner on the road to health for all. Efforts should be made to contain costs and strengthen collaboration between WHO and Member States.

5. TECHNICAL MATTERS

5.1 Technical paper: emerging and resurging diseases in the Eastern Mediterranean Region with special reference to malaria

Agenda item 12(a), Document EM/RC45/9, Resolution EM/RC45/R.3

The item was presented by Dr B. Sadrizadeh, Director, Integrated Control of Disease. He referred to the WHO definition of emerging infectious diseases—"diseases whose incidence in humans has increased during the past two decades or which threaten to increase in the near future". The phenomenon of emergence, he said, was not new in the history of humanity; however, its scope had increased tremendously in recent years. Factors behind the emergence were multiple and interrelated and included those related to humans, environment and pathogens. Many emerging diseases had shown clear epidemic potential and posed a threat to the health of millions of people. Most important for the countries of the Eastern Mediterranean Region were AIDS, Ebola fever, cholera, infection caused by the O157:H7 strain of *Escherichia coli*, hepatitis C and E, some arboviral infections (dengue/dengue haemorrhagic fever, yellow fever and Rift Valley fever), tuberculosis and diphtheria.

Dr Sadrizadeh said that malaria played a special role among re-emerging diseases, due to its high prevalence in the afrotropical countries and its ability to quickly re-establish endemicity in areas where transmission had been brought to a sporadic level or interrupted. During the first half of the 20th century, malaria had been highly prevalent in all the countries of the present Eastern Mediterranean Region. After the Second World War, and especially in the course of WHO-supported malaria eradication programmes during the 1960s and 1970s, transmission of malaria had been interrupted in Cyprus (1953), Lebanon (1963), Jordan (1970), Qatar (about 1970), Libyan Arab Jamahiriya (1973), Bahrain (1979) and Tunisia (1979). In other countries, incidence of malaria had been brought down considerably during the same period (Afghanistan, Egypt, Islamic Republic of Iran, Iraq, Oman, Morocco, Pakistan, Saudi Arabia, Syrian Arab Republic and United Arab Emirates). Progress had continued in some of these countries in the 1980s and 1990s, and malaria transmission was now limited to a few well circumscribed foci in Egypt, Morocco, Oman and United Arab Emirates. However, the malaria situation had not improved in the countries with the afrotropical type of malaria: Djibouti, Somalia, Sudan and Republic of Yemen, while outside the afrotropical areas, malaria had made spectacular comebacks after years of successful control in Afghanistan and Iraq.

In response to the challenge of emerging infections, a global framework had been developed by WHO to guide the collective response of all countries through national and international organizations. In 1996, the Regional Committee for the Eastern Mediterranean had endorsed the regional plan on emerging and re-emerging diseases. Control of emerging infections, said Dr Sadrizadeh, required strengthening of surveillance, promotion of cooperation between neighbouring countries, achievement of self-reliance in production of specific drugs and protection means, and support for applied research. The regional malaria control strategy, based on the revised global strategy for malaria control, had been approved by the Fortieth Session of the Regional Committee for the Eastern Mediterranean (1993) and

included four elements: early diagnosis and prompt treatment, selective and sustainable prevention, control of epidemics, and applied research. Additionally, for countries that had achieved interruption of malaria transmission and were technically in the maintenance stage of malaria eradication, the main strategy was to prevent reintroduction of malaria.

Dr Sadrizadeh said that in countries with afrotropical malaria, control efforts had been intensified, after additional funds of US\$ 1 million in both 1997 and 1998 had been made available by the Director-General of WHO. This had already resulted in strengthening of the malaria control infrastructure and improved training of health workers in Djibouti, Somalia and Sudan, and had promoted intercountry cooperation between them, with the partial involvement of the Republic of Yemen. The Regional Office for the Eastern Mediterranean, along with the Regional Office for Africa, had participated actively in the development of the African Initiative for Malaria control. This initiative would act as a spearhead for the Roll Back Malaria project. Other countries with a serious malaria problem had to take into account epidemiological realities and adjust their malaria control strategies accordingly; they would need to reorient their surveillance systems. For some of these countries, armed conflicts and international sanctions remained a formidable obstacle for any successful malaria control. The countries where malaria eradication was feasible should commit themselves to the goal of complete elimination of malaria transmission in their territories and launch a strong, time-limited attack on malaria in its residual foci, according to the established principles of malaria eradication.

Discussions

H.E. the Minister of Health of Cyprus said that since interruption of malaria transmission in 1953 no indigenous cases had been reported in Cyprus. A maintenance programme was in place to guard against reintroduction of malaria via the Turkish Cypriot Community, and a medical entomology laboratory had been established to monitor insecticide susceptibility and resistance of mosquitos and other disease vectors, and to test appropriate chemicals for vector control. As a result of the work of that laboratory, malaria control activities had been modified and integrated pest management, combining environmental and biological control measures, had been introduced.

The Representative of the Islamic Republic of Iran said that the country had moved from the eradication phase to the control phase; however, the Region lacked professional and experienced human resources in control. He called on countries in the Region to collaborate and share their expertise. With the collaboration of the Regional Office, a regional training centre had been established in the Islamic Republic of Iran to train health personnel in malaria control and was about to graduate its second batch of trainees, who came from countries both inside and outside the Region.

Increased collaboration in the Region was also needed to combat tuberculosis. Here also, training was a key issue and a WHO collaborating centre had been established in the Islamic Republic of Iran for research, training and control. The Representative noted the positive evaluation of the DOTS strategy implementation in his country and called for pooling of experience of this type in the Region.

Surveillance, he said, was the key issue in control of emerging and re-emerging diseases, at all levels but in particular at regional level. The expertise existed but the linkage between countries, and between countries and the Regional Office was weak.

H.E. the Minister of Public Health of the Republic of Yemen said that there were countries in the Region, including his own, which continued to suffer greatly from the burden of malaria. The disease warranted strong global and intercountry collaboration and cooperation, and he hoped the Regional Office would take the lead in this regard.

The Representative of Egypt emphasized the importance of intersectoral cooperation, citing the Ministry of Health and Population's experience with the Ministry of Agriculture and Irrigation to combat malaria in Fayoum Governorate which had led to the elimination of malaria in that focus. International cooperation was also important and should be encouraged between neighbouring countries. Egypt and Sudan, for example, had enjoyed good collaboration in malaria control. The surveillance system and proper management of the information system were similarly of great importance.

H.E. the Minister of Health and Population of Egypt said that malaria control activities needed to be implemented at the level of the Region as a whole and not at the national level. Egypt had succeeded, through cooperation with Sudan, in controlling malaria in the border areas between the two countries. He emphasized the importance of training and the need to use the expertise available in the Region in this respect.

The Representative of Tunisia said that all Member States ought to take the measures necessary to control emerging and resurging diseases, adding that this task required great skill and sophisticated technology. In Tunisia, certain diseases were being monitored and followed up. In addition, human resources had been developed through training, and laboratories had been strengthened. As regards malaria, although infection transmission had stopped as of 1977, control activities had not.

H.E. the Federal Minister of Health of Sudan reviewed the experience of his country in the field of malaria control, saying that it was characterized by political commitment and intersectoral collaboration. Sudan had started a malaria control initiative in eight states, and a plan of action had been established, based on three axes: political support, provision of necessary funds and community involvement. He introduced a member of the delegation, the Deputy-Governor of Gezira state, who described the experience of Wad Medani where seven states are collaborating with Gezira in malaria control. This initiative was being extended to other states.

The Representative of Iraq said that the paper did not include certain diseases which had actually resurged in the Region. He added that the impact of the stratosphere on the environment needed further research and that the same applied to tropical diseases, particularly after the emergence of new disease vectors. New cases of malaria had occurred in Iraq, although transmission had stopped as of 1977.

The Representative of Pakistan noted that the incidence of malaria in his country had decreased from 13 per 1000 population in 1973 to less than 1 per 1000 in 1997. The main objectives of the malaria control programme were to maintain incidence at a level of 0.5 per 1000 population, to progressively reduce reliance on the use of insecticides and to promote alternative methods of control such as environmental management and biological control. Steps had been taken to integrate the malaria control programme into primary health care. Constraints included the lack of health education, the lack of a separate budget for health education at federal level and the exacerbation of the situation in two provinces resulting from the influx of refugees from Afghanistan.

The Representative of the United Arab Emirates said the malaria control programme was one of the most successful in the country and that no new indigenous cases had been reported for a long time. The programme was being continuously reviewed and evaluated, particularly since the country had joined the Tropical Disease Research Committee. He added that there was a joint United Arab Emirates/WHO headquarters programme being implemented with a view to using larvicidal fish to control malaria. He also affirmed that the national malaria control programme would be maintained and sustained to prevent the resurgence of the disease, particularly in years with heavy rainfall.

The Representative of the Libyan Arab Jamahiriya said that malaria had resurged in his country. He stated that the cases previously detected had all been imported. However, the disease had been recently detected in two children who had never been outside the country. This showed that malaria was being transmitted in the country. He concluded by asking about the current situation with regard to malaria vaccines.

Dr Tore Godal, Acting Project Manager, Roll Back Malaria, WHO headquarters, said that the Roll Back Malaria (RBM) project was intended to address malaria within the context of health sector development and intersectoral collaboration. WHO would provide strategic support for a global partnership in which WHO would take the lead in a common plan with United Nations agencies and other partners. The World Bank, for example, was looking at new instruments of lending whereby action might be taken much more quickly and be sustained. The Director-General, he said, was keen that WHO should act as one united entity in RBM. In this regard, RBM and the African Initiative for Malaria were being merged into one plan of action. The basic concept of RBM was to add value to existing activities rather than to duplicate them. It would build on the current global strategy and be based on regional and epidemiological characteristics, including those of local health systems. He would welcome input from countries to the draft report of the RBM team.

Referring specifically to the comments of the representatives he noted three points. First, it was clearly important to prevent the resurgence of malaria in the Eastern Mediterranean Region. WHO could provide support to help build up capacity through a resource network. Second, it was important to pool the available resources and share regional experiences in a pragmatic approach based on epidemiological needs. Third, while it was clear that technical expertise was available in the Region, individual countries were weak in this area. The headquarters RBM team would visit the Regional Office to ensure

joint action regarding malaria. It was anticipated that financial support would be forthcoming from various areas, including the G8 group of industrialized countries.

Concluding the interventions, H.E. Dr El-Hédi M'henni, chairing the Meeting, acknowledged the efforts made by the Saudi Arabian health authorities to care for the health of pilgrims and to ensure that the health situation was good, especially during the pilgrimage season. He urged all Muslim countries to back up these efforts by supporting pre-pilgrimage preventive health measures to be taken by each country for the protection of the health of its pilgrims, including medical tests, detection of communicable diseases and immunization against infectious diseases. He concluded by expressing the hope that the pilgrimage season would be a season when all Muslims meet in the best condition for them to perform the rites of pilgrimage. He emphasized the fact that the control of communicable diseases, whether endemic or emerging, necessitated the involvement and participation of all sectors and parties to ensure the feasibility and sustainability of health programmes within the framework of a well coordinated strategy with well defined objectives.

5.2 Technical paper: cardiovascular disease prevention and control

Agenda item 12(b), Document EM/RC45/10, Resolution EM/RC45/R.7

The item was presented by Dr A. Alwan, Director, Health Services Development. Developing countries were experiencing dramatic changes in the health needs of their populations. Although many countries currently faced a double burden of infectious diseases and noncommunicable diseases, the latter, including cardiovascular diseases, were fast replacing such traditional enemies as infectious diseases and malnutrition as the leading causes of disability and premature death. Epidemiological transition, he said, was taking place as a result of the aging of populations, progressive urbanization and socioeconomic transformation, changes in nutritional patterns, increased cigarette smoking and a more sedentary lifestyle.

Dr Alwan said that the past 30 years had seen a considerable change in food consumption patterns. The per capita food energy and protein availability had doubled and fat availability had increased threefold. At the same time, the increase in the availability of vegetables and fruits had not been consistent during this period. Available data indicated a considerable and progressive increase in tobacco consumption over the past three decades. Imports and manufacture of cigarettes were increasing. Data also demonstrated increased rates of smoking in populations of the Region, especially among young people and also among women. Very little was known about physical activity in the Region on a population basis. Diabetes and impaired glucose tolerance, recognized risk factors for coronary heart disease, were increasingly encountered.

Several well designed epidemiological surveys on diabetes in the Region over the past decade had delivered the consistent and disturbing message that diabetes in these populations was considerably more prevalent than in Europe and north America. Published results of epidemiological studies reported a prevalence of diabetes of around 10% among populations aged 20 years and over. In many countries of the Eastern Mediterranean Region,

this important feature of the "epidemiological transition" was already much further advanced than many health policy-makers appreciated.

Although health officials and the medical profession had a general awareness of the increasing occurrence of cardiovascular disease, the problem had, in general, not received the attention it deserved and its extent had not been sufficiently examined. Reliable and complete mortality data were difficult to obtain, said Dr Alwan, and many countries still did not report death by cause. However, data reported from Bahrain, Cyprus, Egypt, Iraq, Jordan, Kuwait and Qatar over the past few years provided useful indicators of mortality trends. In these countries cardiovascular disease was the leading identifiable cause of death. Coronary heart disease seemed to be the predominant type of cardiopathy encountered in many countries. Data on hypertension had been reported from many countries and hypertension had been reported to affect more than 20% of adults.

Since treatment of established cardiovascular disease was expensive and often ineffective, prevention was the best way of avoiding growth in the burden of these diseases and in unnecessary health care expenditure. There was considerable evidence from various scientific disciplines testifying to the preventability of coronary heart disease. Generally speaking, four levels of prevention could be identified, corresponding to different phases in the development of disease: primordial, primary, secondary and tertiary. All were important and complementary, although primordial and primary prevention had the most to contribute to the health and well-being of the whole population. Dr Alwan reviewed these four levels of prevention, with special emphasis on approaches and priorities for the Eastern Mediterranean Region.

Several countries, he said, had now recognized the need to initiate demonstration or pilot projects for community-based interventions for the primary prevention of cardiovascular diseases. WHO was collaborating with the Islamic Republic of Iran, Lebanon and Oman in establishing such projects. A regional plan for cardiovascular disease prevention and control had been prepared and, since formulation of the plan in 1994, many countries had made significant progress towards the achievement of the targets set for 1997. However, although standardized data were now available in more than 60% of countries, studies conducted during the past few years in more than half the countries of the Region had focused primarily on the epidemiology of cardiovascular risk factors. Little progress had been made in strengthening mortality statistics, and accurate data on the causes of death were still not available in many countries. Similarly, although several countries had taken action to control cardiovascular disease over the past four years, only a few had developed comprehensive action plans.

In conclusion, Dr Alwan said that cardiovascular diseases were emerging as the leading cause of mortality in many countries of the Region. The enormous burden caused, in terms of suffering and health care costs, was escalating. The Regional Committee was requested to advise on further mechanisms that would stimulate action by countries to address this major problem.

Discussions

The Representative of the Libyan Arab Jamahiriya noted that most countries, including his own, dealt with cardiovascular diseases risk factors separately. He emphasized the need to deal with such factors in tandem, through primary health care centres.

The Representative of Egypt said that there were units in Egypt that screened asymptomatic people for undiagnosed cardiovascular diseases. A recent survey had showed that the rate of rheumatic heart disease among children was declining.

5.3 Technical paper: GATT Agreement—its impact on health

Agenda item 12(c), Document EM/RC45/11, EM/RC45/R.10

The item was presented by Dr A. Saleh, Director, Health Policy and Management. He spoke briefly about the various World Trade Organization (WTO) agreements that may have direct or indirect impact on health. These included the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), Agreement on the Application of Sanitary and Phytosanitary Measures (SPS), Agreement on Technical Barriers to Trade, General Agreement on Trade in Services, Uruguay Round Protocol GATT—1994, Agreement on Agriculture, Decision on Measures Concerning the Possible Negative Effects of the Reform Programme on Least-Developed and Net Food-Importing Developing Countries, Agreement on Trade-Related Aspects of Investment Measures, Agreement on Implementation of Article VI (Anti-Dumping), Agreement on Rules of Origin and Agreement on Safeguards.

The WHO Regional Office for the Eastern Mediterranean had, he said, alerted Member States to the possible impact of WTO Agreements on the health sector. It had participated in several national meetings discussing the impact of TRIPS on the local drug industry. One of the main recommendations of these meetings was the need to establish a joint expert group representing economists, lawyers and technical experts as well as policy makers to discuss WTO agreements and develop national and regional plans for the coming years, to best prepare the health sector for the full implementation of WTO agreements. Of special importance was what the Regional Office could do to strengthen national and regional contributions to technology development and allow countries to benefit from TRIPS and other WTO agreements.

Dr Saleh said that the impact of the WTO agreements had also been discussed at the twenty-first meeting of the Eastern Mediterranean Regional Consultative Committee, held in the Syrian Arab Republic in May 1997. In addition, the Regional Office had organized a consultation in September 1997 on the WTO agreements and their impact on health, and in particular, the pharmaceutical sector. It was clear that the implementation of the various WTO agreements would have an impact on the health sector. The agreements strongly promoted protection of intellectual property rights, free global trade and services, and harmonization of international standards, and referred to encouraging development and economic reform. They took into account protection of health and environment, but the interests of developing countries, in particular the social sector including health, did not appear to have been taken into consideration during the negotiation phase.

More comprehensive studies were needed to investigate the impact of various aspects of WTO agreements on the health sector including cost of health services, in particular cost of drugs and other health technologies; drug import/export and national drug policy; transfer of health technology and health services providers; the role of the government, and in particular health legislation; standard-setting, both at national and international levels; and patency rights of technological development in developing countries. Dr Saleh noted the importance of WHO taking the necessary steps to study the possible effects of the WTO agreements on the health sector at both national and international levels. The role of WHO in setting international standards should be emphasized. It was also important, he said, to establish national committees to coordinate national response and future negotiations of WTO agreements. Ministries of health might take the initiative in calling for the establishment of such committees.

Discussions

The Representative of the Islamic Republic of Iran noted the potential negative impact of the WTO agreements on local manufacturing capacity of pharmaceuticals in developing countries, including loss of local jobs and impact on essential drugs lists and consequently primary health care. He proposed that WHO work with countries to study the impact of the agreements on national drug policies. Countries might also need to consider the impact of the agreements with regard to possible increase in irrational use of drugs. He said it was important also to find ways to ensure availability of essential drugs was maintained through support to certain local pharmaceutical companies. He acknowledged that the agreements might reduce the price of essential drugs in the short term but at the cost of the integrity of local manufacturers, while in the long term they might result in increased prices, especially for new drugs. He suggested Member States cooperate in a time-limited programme to assist in adopting or adapting to the agreements. He also suggested the setting up of a pharmaceutical information network between countries to increase trade in the Region and absorb some of the impact.

The Representative of Sudan said that the agreement regarding the Trade-Related Aspects of Intellectual Property Rights (TRIPS) would seriously affect, in the short and long term, the provision of drugs in the developing countries, as their limited foreign exchange resources were limited, and would also affect their ownership of pharmaceutical manufacturing industries. He requested the World Health Organization to discuss these effects with the WTO, and urged the developing countries to make the best use of the transition period, which extended until the year 2006, for building their capacities.

The Representative of Egypt reiterated the previous comment saying that TRIPS would have a negative impact on the accessibility of health care, medical equipment and drugs at reasonable costs. He added that certain multinational pharmaceutical companies had succeeded in introducing very expensive drugs into the Egyptian markets, and that other companies, which produced drugs in Egypt under licence, were in the process of stopping this practice, thus paving the way for drug importation. The signing of the agreements did not necessarily mean the cessation of negotiations regarding their impact on health.

The Representative of Jordan urged Member States to adopt a uniform strategy and called upon WHO headquarters to prepare the strategies and plans of action necessary for addressing the health problems that might arise as a result of the implementation of the WTO agreements, and remedy the state of affairs, preventing a situation where there were two types of medicine, one for the poor and one for the rich.

H.E. Dr Abdel Rahman Al-Awadi, President of the Islamic Organization for Medical Sciences, said that the WTO agreements sought to control the world through food and treatment. He added that these agreements had been discussed over many years, yet WHO had not perceived a need to conduct any negotiations regarding their impact on health. Negotiations conducted by WHO should be forceful and serious.

The Representative of Sudan called upon WHO headquarters to continue and expand the ongoing studies related to the impact of the WTO agreements on health, and to see to it that such studies were distributed to Member States.

The Regional Director said that he endorsed the opinions put forward. The problem however, lay in the fact that the ministries of health were not the only authorities concerned. The agreements dealt with agriculture, industry and trade, but ignored the human aspect. The World Health Organization's Constitution stated that it was the right of all people to enjoy good health. Accordingly, the agreements ought to be reconsidered, with a view to including the human and health aspects.

The Regional Director then suggested that a sum of money be made available from extrabudgetary resources and used by WHO, either to purchase some drug patents and manufacture such drugs at low costs or to participate in the cost of drug studies and research conducted by the pharmaceutical companies, in which case WHO would have a say in deciding the price of drugs. He also noted that the manufacturing companies determined exaggerated costs for the research studies they conducted.

5.4 Progress report: acquired immunodeficiency syndrome (AIDS) in the Eastern Mediterranean Region

Agenda item 13, Document EM/RC45/12, EM/RC45/R.6

The item was presented by Dr M.H. Wahdan, Assistant Regional Director. The epidemic of HIV/AIDS was continuing to spread, with an estimated 5.6 million new infections in 1997 (or about 16 000 per day). More than half of these were young persons 15 to 24 years of age. At the end of 1997, 30.6 million persons were living with HIV infection, most of them in developing countries. The number of cases of AIDS reported to WHO as at end 1997 was 1 890 000 but the actual cumulative total was estimated to be 13 million cases, of whom 12 million had already died, including 2.3 million in 1997.

In the Eastern Mediterranean Region, 6158 cases of AIDS had been reported up to end-1997 but the actual number might be about 20 000. The number of reported cases was increasing every year, said Dr Wahdan. More and more women were suffering from AIDS, while the number of cases due to contaminated blood and blood products was decreasing

steadily. About 250 000 persons were estimated to be living with HIV infection in the Region at the end of 1997. The exact magnitude of sexually transmitted diseases (STD) in the Region was not known but was considered to be not insignificant. About 10 million cases were estimated to occur every year. A few Member States of the Region had prepared STD control programmes and had started implementing them.

Dr Wahdan said that, although WHO's resources had diminished with the closure of its Global Programme on AIDS, WHO continued to play an important role in prevention and control of AIDS and STD in the Region. It continued to provide technical and financial support to the national programmes within its available resources. Technical support included assignment of staff and consultants, fellowships and provision of guidelines. Financial support had been provided for purchase of HIV and STD test kits, condoms, audiovisual equipment and educational materials and for such local cost activities as training, production of educational materials, surveillance and collaboration with nongovernmental organizations.

The Regional Office had organized eight intercountry meetings during 1996–1997 in the fields of programme management, surveillance, evaluation, blood safety, care and STD control. It now published a quarterly newsletter *EMR AIDSnews*, had developed some guidelines on aspects of HIV/AIDS/STD and reprinted a number of documents which were in demand.

As one of the cosponsors of UNAIDS, WHO had continued to play an important role at the regional and country levels. The Regional Office had carried out a number of activities in collaboration with UNAIDS. These included the development of guidelines, publication of educational materials and organization of intercountry meetings. As the AIDS epidemic continued to spread, the Regional Office had continued its advocacy role for high national commitment to AIDS/STD programmes and for a multisectoral approach to fight the epidemic.

Discussions

The Representative of Iraq emphasized the importance of health education in AIDS control, noting with appreciation the health education training provided by the Regional Office, and proposed that this activity continue. Routes of transmission other than the sexual route should be given attention. Nongovernmental organizations were called to support treatment efforts considering the high costs of therapy.

The Representative of Lebanon said that the AIDS control programme in Lebanon concentrated on prevention activities, including intersectoral activities and activities carried out by the private sector. The programme had now moved to strengthening surveillance activities. Treatment costs were extremely high. Some AIDS medicines were not effective, and resistance was developing to others. He asked WHO's opinion about AIDS medicines.

The Representative of Sudan said that his government had spared no effort to control the AIDS epidemic, noting that Sudan had a disadvantage due to geography. It had nine

neighbouring countries, each with its own problems, which in turn affected Sudan. This plus Sudan's own problems had negative effects on AIDS control activities, notwithstanding the efforts of case monitoring, blood screening and health education of citizens. Hence his country was in need of WHO technical support.

The Representative of Tunisia emphasized the importance of continuous vigilance and noted that the necessary resources were on the decline. As regards AIDS treatment, he called for informing people, especially AIDS victims, of the drugs available, their costs and their efficiency. He warned against global monopolies in AIDS medicines.

The Representative of the United Arab Emirates commended WHO collaborative efforts with Member States in the field of AIDS prevention and control, and called for continuing preventive efforts and health education on ways of prevention. He emphasized the importance of WHO meetings for national programme managers to share their experiences. He also noted that AIDS medicines were very expensive.

The Representative from the Islamic Republic of Iran said that the AIDS hazard was still an epidemiological iceberg, the visible portion being dwarfed by that which was concealed under water. The peak in the Eastern Mediterranean Region, he added, was less visible than those in other regions. UNAIDS had weakened the role of WHO as a technical leader, an issue raised in a recent World Health Assembly. National coordination committees chaired by the respective WHO Country Representatives had been created to bring together all agencies concerned in the fight against AIDS, he said, but these committees had not proved effective enough. As control of HIV/AIDS was not the responsibility of one agency, more options for coordination should be considered. Most countries in the Region shared a common culture, and this should be exploited in controlling the epidemic.

The Representative of Saudi Arabia said that cases were imported to the GCC states through expatriate human resources. He stressed the importance of comprehensive and reliable information and called for the establishment of centres of excellence to be responsible for this tasks. Hepatitis, he said, should also received due attention.

The Representative of Bahrain stressed the importance of continuing preventive efforts as well as control activities and called for establishing home care programmes for AIDS patients, as adopted by many countries, considering the high cost of treatment in health care centres and hospitals.

The Representative of Pakistan reiterated that the Region had been spared the worse of the AIDS epidemic because of its religious and social background. However, there was no cause for complacency, and more efforts were needed to educate people about HIV/AIDS.

H.E. the Minister of Public Health of Morocco said that all risk factors had to be thoroughly studied in order to avoid the occurrence of new cases. He asked for the adoption of a strategy concerning the triple-drug antiretroviral combination therapy for AIDS, and for giving due attention to all sexually transmitted diseases and not only AIDS.

The Representative of Egypt described some of the activities carried out by the national programme including the "hot line", a telephone line open for 16 hours a day to answer questions received from those suffering from symptoms and provide them with necessary information and advice. He also referred to anonymous testing in order to encourage discovery of cases.

Dr Jihane Tawilah, UNAIDS Intercountry Programme Adviser in the Eastern Mediterranean Region, thanked WHO on behalf of UNAIDS Executive Director Dr Peter Piot for the chance to participate for the first time in the Regional Committee for the Eastern Mediterranean. Referring to section 5 of the Regional Committee background paper, she stressed that UNAIDS was not a funding agency, correcting a common misconception that had caused problems in the past biennium. UNAIDS' role at the country level was to support and develop national response. She also advised the Committee that funds made available to UN agencies for combating HIV/AIDS in the 1996-1997 biennium were US\$ 2.6 million, not US\$ 1.3 million, as stated in the background paper, covering direct support to country programmes, regional meetings and through Geneva staff.

The secretariat of UNAIDS, she said, worked as one body through Country Programme Advisers and Intercountry Programme Advisers, as well as through cosponsors, and there were no regional UNAIDS bodies. UNAIDS worked through cosponsors at regional level but country-level work was the main focus. She drew the attention of the meeting to country experiences such as the successful United Nations theme group in Sudan. UNAIDS had enjoyed excellent collaboration with WHO and UNICEF in the Region, and there was now a collaborative plan with the Eastern Mediterranean Regional Office specifically addressing country needs, covering control of sexually transmitted diseases; access to care, including vertical transmission of HIV; and, most important, the launch of a regional vulnerability initiative. Borrowing from the terminology of control of cardiovascular diseases, she called for "primordial prevention" and studies on the determinants of STD and on vulnerability issues for STD and AIDS. Efforts must be made to share experiences and best practices between countries in prevention and control of STD/AIDS.

Although prevalence in the Eastern Mediterranean Region was not high, she warned that the information available was sketchy and poorly distributed, and that the statistics gathered had no common basis for comparison. She said that there was not one single epidemic in the Middle East; rather, the epidemic had many faces in the Region, with certain groups specifically at risk of infection. Such groups included migrants, injecting-drug users and sex workers, as referred to in the background paper. There was a growing problem in the Region and inevitable gaps in response, as well as a need for more information and dissemination of lessons learnt. Intervention must therefore be focused and targeted.

There was also a need for greater advocacy on the part of the United Nations leadership, including WHO, to educate the public and influential sectors of society such as the media and national authorities to prevent panic, discrimination and irrational action based on imperfect knowledge of the issues.

Dr Tawilah said that access to therapeutic drugs was important. Although drugs were expensive and thus inaccessible to most in the Region, mechanisms such as voluntary testing and counselling schemes had to be in place for when access to such drugs became available. A UNAIDS initiative addressing the problem of access to drugs had been established and was being piloted in a few countries.

The UNAIDS Representative reviewed some of the prevention strategies characteristic to the Region and proposed by the Eastern Mediterranean Regional Office, such as early marriage, but stressed that studies must be made to test the effectiveness of such approaches and advise countries on appropriate means and tools by which they might be put into operation. There was need as well to develop the religious approach.

Dr Wahdan spoke about available treatments, including the triple-drug antiretroviral combination therapy for AIDS. He also referred to the fact that these drugs were very expensive (US\$ 1000–1500 per month), difficult to comply with, and had very serious side effects. He then referred to the WHO consultation on treatment of AIDS and the priorities in this regard, the first of which was the treatment of pregnant women to avoid mother-to-baby transmission.

5.5 Progress report: development in nursing and midwifery

Agenda item 14, Document EM/RC45/13, Resolution EM/RC45/R.12

The item was presented by Dr A. Alwan, Director, Health Services and Development. He noted that this progress report provided an update on the status and progress of nursing development in the Eastern Mediterranean Region, particularly in relation to World Health Assembly resolutions WHA45.5 and WHA49.1, Regional Committee resolution EM/RC41/R.10 and the regional strategy for nursing and midwifery. The report addressed the actions taken by Member States in the Eastern Mediterranean Region in relation to areas outlined in the regional strategy:

- establishing and strengthening nursing units in the ministries of health in order to undertake the development of national plans and strategies for improving nursing education and service delivery;
- improving nursing education, basic and post-basic, in order to graduate competent practitioners who are accountable for the delivery of nursing services in hospitals and various community-settings;
- regulating the practice of nursing education and service by enacting legislation, and establishing registration and licensing systems and codes of professional conduct;
- promoting the development of nurse managers and leaders so that they may participate in setting policies and procedures for patient care standards and measuring outcomes of nursing care, and be involved in strategic and operational planning for health development;

- improving quality of nursing care practice through adoption of systems of quality improvement, continuing education and nursing personnel management;
- encouraging nurses' participation in research and developing research-based practice to improve quality of care.

The report also addressed the support provided by the Regional Office to Member States. Dr Alwan noted that regional standards for basic and post-basic nursing education for the Eastern Mediterranean Region had been developed in collaboration with the Regional Advisory Panel on Nursing and regional nurse educators. Prototype curricula had been developed for both technical and professional education for use as guidelines by nurse educators in the Region. In addition, focus had been placed on WHO's role in supporting efforts to strengthen national capacity in various aspects related to nursing development; 70 fellowships had been granted to nationals from 14 countries for advanced preparation in nursing education, nursing quality improvement, nursing services management and clinical practice. Moreover, since 1994, 62 short-term consultants, temporary advisers and national experts had been fielded in countries of the Region to assist nurse leaders in developing national action plans, develop post-basic specialization programmes, assist in developing and revising nursing regulations and provide training in nursing management.

Discussions

The Representative of Qatar said that the health policy of any state should include programmes for nursing education and development, as nursing was a very important component of the health services. The achievements made in Qatar included the establishment of a special body, within the Ministry of Public Health, for the formulation of nursing policies; the gathering of information on nursing human resources; the establishment of a computerized system for the registration of all the graduates of nursing schools; and the establishment of an advanced diploma degree in nursing, enrolment to follow completion of secondary school studies.

The Representative of Egypt said that there was nowadays a trend towards focusing on theoretical studies rather than on practical training in the field of nursing; what was really needed, he said, was to provide nurses with intensive practical training. He felt that the requirements for admission to nursing schools should not be raised.

The Representative of the United Arab Emirates said that the Ministry of Health in his country had taken action to strengthen the role of nursing in the provision of health services by: 1) the establishment of the Central Nursing Department in 1992 to manage nursing affairs, develop standards and criteria aimed at the development of nursing care, and plan the size of the nursing corps; 2) the development of written national plans on nursing; 3) increasing the number of nursing schools in several emirates and developing the higher nursing diploma; 4) the development of regulations and legislation to promote nursing; 5) the drawing-up of national nursing personnel profiles through an information system containing essential data about those personnel; and 6) the standardization of performance criteria to ensure the provision of nursing services under certain criteria defined at the level

of the Ministry of Health. He pointed out that interest in joining the nursing profession had increased after the Ministry of Health had raised the salaries of nurses and had taken upon itself the responsibility of finding jobs for them upon graduation.

The Representative of Bahrain said that the programmes for basic and post-basic nursing education had been reviewed, the necessary standards and criteria established, and a draft nursing code of conduct prepared. She added that she did not agree with the Representative of Egypt, that what nurses lacked was practical training. She believed that the knowledge of nurses should be developed and increased, so as to enable them to become partners in health decision-making.

The Representative from the Islamic Republic of Iran commented on behalf of the Iranian Nursing Office. He advised Member States to set up educational committees to ensure high-quality nurses. It was important, too, to assess local and national priorities. All countries should have a continuing education programme for nurses to enable them to respond to developments in medicine and technology in order to provide better care; WHO could help design a framework for such a programme. He also called on countries to give nursing a higher profile in ministries of health.

The Representative of Lebanon said that nursing education programmes focused on patient care, while they should include aspects relating to public health, not patients. He also said that there was legislation in Lebanon relating to the graduation of assistant nurses, a category of health personnel that might assist in solving the problems of nurse shortages.

The Representative of Sudan mentioned that there existed in her country various categories of nursing personnel including educated midwives, non-educated midwives and nurses. He added that they also had schools for primary, intermediate and higher nursing education, and that they had cancelled the intermediate level. The nursing teaching curricula and the conditions of work were being currently reviewed, and the introduction of research in the field of nursing considered. He wondered whether it would be preferable to have just one category of nurse, and whether his country should focus on practical training or on academic teaching.

6. TECHNICAL DISCUSSIONS

6.1 Regional self-sufficiency in vaccine and drug production

Agenda item 10, Document EM/RC45/Tech.Disc. 1, Resolution EM/RC45/R.5

The item was presented by Dr A. Alwan, Director, Health Services Development, who reviewed the status of production of drugs and vaccines in the Eastern Mediterranean Region, identified the major constraints in the quest for regional self-reliance and proposed strategies to overcome them. Dr Alwan said that although drug production in the Region dated back to the 1930s, most progress had been made in the past three decades. During this time, drug consumption had increased considerably. He referred to data reported by the Arab Company for Drug Industries and Medical Appliances (ACDIMA) and the Arab Union of Manufacturers of Pharmaceuticals and Medical Appliances for the Arab countries¹ for 1975 to 1996. These data showed that the total drug market rose from US\$ 785 million in 1975 to US\$ 4144 million in 1996. However, the proportion of locally produced drugs, most of which were formulations, remained at just over 40%. In some countries, about 40% of drugs were produced under licence. More than 90% of the raw materials needed for local production were imported. The drug market in all countries of the Region was estimated at nearly US\$ 6 billion in 1996. There were more than 540 manufacturers, and 35 new facilities were in the design stage or under construction. There was a wide variation in the annual per capita spending on drugs between the different countries in the Region, ranging from US\$ 1 to US\$ 80.

Only four countries of the Region, said Dr Alwan, had vaccine production capabilities: Egypt, Islamic Republic of Iran, Pakistan and Tunisia. Of these, only the Islamic Republic of Iran was self-reliant in the local production of vaccines and other immunizing agents. Pharmaceutical raw materials were produced only in Egypt, Islamic Republic of Iran and Pakistan. Local production of these materials was still at an early stage of development and output did not cover more than 10% of the demand at the national level.

In conclusion, Dr Alwan said that self-reliance in the production of essential drugs and vaccines faced considerable challenges. Despite commitments to develop local production within the Region, production volume in most facilities did not meet national needs. Moreover, there was little capacity for export. Independent national control authorities, a key element in vaccine production and in developing a sustainable market, were not fully in place in the producing countries.

Discussions

The Representative of Jordan noted that the paper spoke of acceptable and unacceptable quality standards, pointing out that quality was an indivisible whole; a vaccine

¹ Arab countries here are the Arab countries of the Eastern Mediterranean Region, not including Djibouti, plus Algeria and Mauritania (African Region).

is either good or bad. He said that some Arab markets were not open to Arab drug sales; efforts had to be made to reverse this situation in order to promote the drug industry in general. Drug control, he said, was a responsibility of the national authorities. Links had to be strengthened between universities and research centres. Capacity-building in drug and vaccine testing and available of modern technology for the drug industry had to be given careful attention.

The Representative of the Islamic Republic of Iran said that local production of drugs and vaccines was essential. Availability of high-quality vaccines could prevent many diseases and the economic consequences of such diseases, both for the health system and the community. Vaccine self-sufficiency should ensure availability, but it was important for manufacturers (and distributors) to follow WHO quality statements. The Representative also called for bacterial seeds to be made available to vaccine producers. Although the countries of the Region could help each other in terms of vaccine production, country's should give priority to becoming self-sufficient in their own country before exporting products.

The Representative of Iraq called for making available to those countries in need the raw materials and modern technology necessary for the drug and vaccine industry, and establishing a true and strong partnership for health between the public sector and the private sector, as partners not adversaries. He emphasized the importance of research and development as well as making available the necessary facilities.

The Representative of the Republic of Yemen said that some countries allowed the base-minded to produce counterfeit drugs, which were smuggled to many countries, including the Republic of Yemen. Efforts had to be made to identify and punish producers of such drugs. The Representative inquired about WHO's role in this respect.

The Representative of Egypt said that pharmaceutical products produced within the Region should be given priority over those produced outside the Region so long as they were of no less quality. He thought that the pharmaceutical industry in the Region would be badly affected by the WTO agreements. Collaboration between petrochemical and pharmaceutical industries, he said, should be secured.

The Representative of Pakistan noted that Pakistan had inherited no pharmaceutical capability at independence in 1947 yet had made great strides since then. A national pharmacopoeia listing 1036 drugs was compiled in 1964, and a drug control administration set up in 1965. Today 300 pharmaceutical manufacturing units (including 27 multinationals) were annually producing US\$ 1 000 000 000 worth of drugs to international standards of quality which met 75% of the country's needs. Surpluses were exported to Africa and Asia. Pakistan had attained almost complete self-sufficiency in drug formulation and had made progress in the manufacture of raw materials. Pakistan was also one of the four vaccine-producing countries in the Region and had signed the agreement for the establishment of the International Vaccine Institute.

The Representative of Sudan said that developing countries should develop their research and development capabilities. He emphasized the need to conduct research on

medicinal plants in order that herbal medicines could be produced and registered for the sake of those countries that developed them. The world market, he said, was not open to pharmaceuticals produced in some developing countries; efforts should, then, be made to correct such imbalance. He condemned the United States' strike against Al-Shifaa pharmaceuticals plant in Sudan, noting that the strike had harmed much of the drug industry in Sudan.

The Representative of Bahrain asked WHO to organize training courses on drug quality certification.

The Representative of Tunisia called for the marketing of drugs at the regional level and giving careful attention to the development of the Region's capability in quality assurance systems in order to strengthen its ability to compete in the global markets.

H.E. Dr Abdel Rahman Al-Awadi, President of the Islamic Organization for Medical Sciences, said that the problems relating to the drug industry in the Region was one of long standing and was related to quality and quality control. It was time that the industry moved to wider horizons and that all aspects of the industry, including coordination, research and development quality control and assurance received careful attention, in order to confront global monopolies in the near future.

Dr Muwaffak Haddadin, Director of the Arab Company for Drug Industries and Medical Appliances (ACDIMA) said that the drug industry was more advanced than the vaccine industry. He noted that there was severe competition, in a relatively small market, between companies with similar products, hence coordination and perhaps mergers among them was required. Some producers, he also noted, neglected good manufacturing practices whose importance need not be overemphasized. He called for the production to be on a trade scale in order to be able to dispense with government support. Drug companies should be encouraged to carry out research and development activities, noting that ACDIMA had funds for that purpose. Regarding the vaccine industry, the ministry of health should be a partner in that industry and a consumer of its products.

Dr Gezairy said that holding companies should be established in countries when there were many small companies competing to produce specific products in the same country. Holding companies could also be established between groups of countries, e.g. member states of the Gulf Cooperation Council or the Maghreb countries, to secure necessary coordination and quality assurance activities and to supervise research and development activities. The Regional Director also noted that drug registration was now used to protect local industry in a country against those in other countries. He emphasized the importance of cooperation between countries in the registration process, in order to reduce costs and improve quality. This, the Regional Director said, required decisions by the governments themselves, noting that WHO and other agencies concerned had no role in this matter.

Dr Alwan in reply to the representatives' interventions, said that he supported all the points the Regional Director had mentioned. He said that he accepted that quality meant meeting the quality requirements defined by WHO. Complete self-sufficiency could of

course never be achieved; however, every effort should be made to increase local production to the extent possible. He also supported the call for securing technology and new material; strengthening collaboration with the private sector; giving priority to purchasing pharmaceuticals produced within the Region, taking into account the fact that coordination between countries was lacking; giving attention to the training in drug inspection, noting that the Regional Office had secured such training in collaboration with the Ministry of Health and Population, Egypt; and supporting manufacture and quality control of herbal medicines. Dr Alwan added that WHO strategy provided for collaboration with Member States in quality assurance and control. The information contained in the paper presented had been obtained from the drug industry in Egypt, Islamic Republic of Iran and Pakistan and not only from ACDIMA. He thanked ACDIMA for being willing to support research and development activities.

Finally, the Chairman of the Technical Discussions stressed the importance of WHO collaboration with Member States in all aspects and fields mentioned in the paper and in the interventions of the representations, in order that the hoped for self-sufficiency might eventually be achieved.

7. OTHER MATTERS

7.1 Resolutions and decisions of regional interest adopted by the Fifty-first World Health Assembly and by the Executive Board at its 101st and 102nd sessions *Agenda item 6*

a) Other resolutions

Agenda item 6(b), Document EM/RC45/4(b)

Dr M.H. Khayat, Deputy Regional Director for the Eastern Mediterranean, presented this item. First he dealt with Executive Board resolution EB101.R1, Programme budget evaluation, pointing out that WHO had long adopted the programme budget approach, which identifies certain goals and products and the means for fulfilling them, as well as the resources required, including financial resources. He added that throughout this period no evaluation of the implementation had ever been carried out. This prompted the Executive Board to welcome, in this resolution, the efforts of the Director-General to develop a methodology to evaluate the programme budget. The Executive Board requested the Director-General to submit an interim evaluation report to the Executive Board's 103rd session, scheduled for January 1999.

The Eastern Mediterranean Management Development Committee reviewed the headquarters document *Guidelines for monitoring and evaluating biennial programme implementation*, and it was decided to test the guidelines in one of the countries of the Region to evaluate the 1996–1997 biennial budget. Based on the results of this pilot test, undertaken in Oman, the Management Development Committee recommended that the statutory 1998–1999 evaluation of the biennial programme implementation at country level be introduced in conjunction with the forthcoming ninth round of Joint Government/WHO Programme Review Missions (JPRMs). It was hoped, said Dr Khayat, that the Eastern Mediterranean Region countries would prepare well for this as JPRM activities would involve detailed evaluation of all national health programmes.

Resolution EB101.R2, Review of the Constitution of the World Health Organization: report of the Executive Board Special Group, dealt with the proposed amendments to the WHO Constitution. It was proposed to amend the definition of health in the preamble to the Constitution, formerly endorsed by the Health Assembly in a previous resolution, to introduce to the definition of health, the notion that health was dynamic and included spiritual well-being; and an amendment to article 50 on adding to the functions of the Regional Committee that of fostering and promoting WHO activities at country level.

Dr Khayat moved to resolution EB101.R16, Efficiency plan for the financial period 1998–1999. Efficiency meant fulfilment of work in the most effective way with the least possible costs. He elaborated that this Executive Board resolution requested the Director-General to develop and present a comprehensive efficiency plan, including a systematic approach to save, through measures of efficiency, 3% from the administrative and overhead costs in the six appropriation sections during the 1998–1998 biennium and to reallocate

these amounts to priority health programmes. He stressed in this connection that the transfer of some programmes from headquarters would be one major way of increasing efficiency.

Some of the ministers commented on these issues after the Director-General's address. She said she was seriously considering such measures.

Following this, Dr Khayat referred to resolution EB101.R21, Collaboration with nongovernmental organizations, emphasizing the importance of the involvement of nongovernmental organizations in many aspects pertaining to the attainment of health for all. He said that the Regional Office had long been involved with nongovernmental organizations in many activities in various fields, and that nongovernmental organizations were instrumental in the control of leprosy, guinea-worm disease, certain aspects of HIV/AIDS prevention and control and more recently in poliomyelitis eradication efforts. All this was evidenced by the strong support provided by Rotary International to regional poliomyelitis eradication efforts and by the exemplary collaboration of dozens of nongovernmental organizations in national immunization days. Another noteworthy example was the cooperation provided by IMPACT in establishing a training programme for physicians on eye diseases in the Republic of Yemen. He also said Regional Office experience in working with national nongovernmental organizations in the implementation of Basic Development Needs projects in six countries of the Region had been highly successful, which supported the trend towards official recognition of such nongovernmental organizations. He further added that the Executive Board had decided in this resolution to establish official relations with a number of nongovernmental organizations, the most important of which was the Islamic Organization for Medical Sciences. For years the Regional Office had been collaborating effectively with the Islamic Organization for Medical Sciences in various priority programmes in the Region relating to important health policy and ethical topics in various disciplines of medicine, medical history and medical culture.

He then dealt with resolution WHA51.8, Concerted public health action on anti-personnel mines, noting that the Eastern Mediterranean Region was one of the most heavily mined regions in the world. The most severely affected countries in the Region were Afghanistan, with an estimated 10 million anti-personnel mines, Somalia with 1 million and Sudan. In addition, Tunisia, Libyan Arab Jamahiriya and Egypt had minefields dating from the Second World War. He added that the Director-General of WHO had, in her inaugural address, urged all countries of the Region to follow Djibouti and Republic of Yemen in ratifying the treaty to ban anti-personnel landmines.

Following this he discussed resolution WH51.10, Ethical, scientific and social implications of cloning in human health, which reaffirmed that cloning for the replication of human individuals was ethically unacceptable and contrary to human dignity and integrity. In the Eastern Mediterranean Region, these aspects had been discussed in a number of national and regional meetings. Of special importance was the expert meeting organized in Casablanca, Morocco, in 1997 by the Regional Office. The recommendations of this meeting represented the regional Islamic views on cloning, the most important of which was to prohibit introducing a third party into a marriage, whether a womb, an ovum, a sperm or a

cloning cell; to prohibit ordinary human cloning in which the nucleus of a living somatic cell from an individual is placed into the cytoplasm of an egg devoid of its nucleus. All countries were called upon to formulate the necessary legislation to prevent foreign research institutes, organizations and experts from direct or indirect experimentation in human cloning or promotion of it. The Islamic Organization for Medical Sciences and other similar bodies were called upon to monitor all scientific developments in the field of cloning. It was recommended that specialized committees be set up to look into the ethics of biological research and adopt protocols for study and research, and prepare a document on fetal rights as a prelude to formulating legislation on the rights of the fetus.

Dr Khayat then spoke about resolution WH51.11, Global elimination of blinding trachoma, noting that trachoma was still a problem in many countries of the Region. A pilot project implementing the SAFE strategy was currently ongoing in Morocco. It was hoped that action plans would be made for all countries in the Region which had identified trachoma pockets in their national surveys. It was also hoped that other agencies would be involved in supporting these national programmes.

Dr Khayat went on to deal with resolution WHA51.17, Emerging and other communicable diseases: antimicrobial resistance, emphasizing that in the Eastern Mediterranean Region, as elsewhere, antimicrobial agents continued to lose their effectiveness. In many countries of the Region antimicrobial agents were available without prescription, resulting in higher resistance rates and interference with the effectiveness of relatively inexpensive antimicrobial medication. Important factors in the emergence and spread of resistance included: misuse, lack of reliable laboratory susceptibility test results, lack of choice of alternative agents, and uncontrolled use. Eighteen countries of the Region had designated national focal point laboratories to participate in the regional network for monitoring resistance to antimicrobial resistance. The Regional Office encouraged countries of the Region to include antimicrobial resistance monitoring activities in their national plans. The response to date remained moderate.

Then followed resolution WHA51.18, Noncommunicable disease prevention and control. In this resolution the Health Assembly recognized the fact that noncommunicable diseases represented a significant and increasing public health problem. It also recognized the various factors, demographic, social, behavioural and environmental behind the increase in noncommunicable diseases. It called on Member States to promote health and control major risk factors for noncommunicable diseases and integrate prevention and control measures within health services, particularly in primary health care. It gave special attention to smoking as a risk factor for these diseases and called for concerted action to control tobacco use all over the world, especially to protect the world's youth against this severe hazard. The above showed that the Health Assembly, by this resolution, had made the control of noncommunicable diseases among its priorities, thus amending its previous resolution adopting priorities set by the Executive Board—priority setting was among the Health Assembly's and not Executive Board's responsibilities, since it related to health policies, according to the WHO Constitution. The Executive Board was responsible for developing strategies. It was hoped that this priority modification would be taken into account at the time of preparation of the WHO programme budget in Geneva.

Dealing with resolution WHA51.28, Environmental matters: strategy on sanitation for high-risk communities, Dr Khayat said that this resolution originated in an idea for WHO to address the need for low-cost sanitation within a new and focused strategy, originally put forward by the Regional Office for the Eastern Mediterranean in 1995. The Regional Office has already undertaken action in the context of the resolution, supporting the establishment of a major sanitation project in Jalalabad, Afghanistan, and the development of demonstration projects in Egypt, Morocco, Oman and Republic of Yemen. As part of the healthy cities and healthy villages programme, sanitation was receiving high priority in Afghanistan (Kandahar), Egypt (Fayoum), Islamic Republic of Iran (nationwide), and Pakistan (Quetta).

Finally, Dr Khayat spoke about resolution WHA51.29, The protection of human health from threats related to climate change and stratospheric ozone depletion. He said that in developing the regional Plan of Action for Health and Environment, priority areas for WHO action in matters of health and environment had been carefully reviewed. Neither the health effects of climate change nor those of increased solar ultraviolet radiation were considered however to be of high priority, by comparison with the very serious specific environmental health issues in the Region, such as drinking-water quality, access to water supply and sanitation, solid waste, vector control, food safety, and domestic combustion of biomass. At the Ministerial Conference on Health, Environment and Development, Damascus, Syrian Arab Republic, December 1997, Bahrain reported that one of the areas of country collaboration with UN agencies in health and environment was a proposed project concerning protection of the ozone layer.

b) Nominations of representatives from the Eastern Mediterranean to the subgroup of the Ad Hoc Working Group on the Revised Drug Strategy

Agenda item 6(c), Document EM/RC45/4(c), Decision 3

The Regional Committee nominated the Islamic Republic of Iran and the Republic of Yemen to serve on the subgroup of the Ad Hoc Working Group on the Revised Drug Strategy.

c) Review of the draft provisional agendas of EB103 and WHA52

Agenda item 6(d), Document EM/RC45/4(d)

The item was presented by Dr M.H. Khayat, Deputy Regional Director. He requested the Regional Committee to submit views on the draft provisional agenda of the 103rd session of the Executive Board and the Fifty-second World Health Assembly in order that they might be forwarded to the WHO Secretariat and finalized after consultation with the Chairman of the Board.

7.2 The role of private and nongovernmental sectors in the national health care delivery system in Lebanon: reform proposals (special presentation)

Agenda item 8, Document EM/RC45/6

The item was presented by Dr W. Ammar, Director-General of Public Health, Lebanon. Dr Ammar spoke of the decline in the provision of health services by the Government during the 17 years of civil unrest, which had affected both the institutional and financial capacities of the public sector. The gap had been filled by nongovernmental organizations and the private sector. As a result, 90% of hospital beds were now in the private sector, and the majority of the existing 850 primary health care centres and dispensaries belonged to nongovernmental organizations.

He noted that licensing was based on outdated standards with poor monitoring, and the private sector consequently continued to grow in a largely unregulated environment, allowing uncontrolled investment and generating a supplier-induced demand. Health services were oriented to curative services at the tertiary level with emphasis on high technology equipment. In contrast, primary health care services lagged, and there was an oversupply of physicians and a shortage of nurses. The poor were underserved by the private sector both in terms of equity and quality of services. The selection of providers by insurers was not based solely on cost and quality, and this fact contributed to increased costs, making purchase of private services by public funds barely affordable, and threatening the sustainability of the current system. Consumer perceptions of quality of care linked to high technology had resulted in increased inefficiency.

The bulk of Government health expenditure was spent on purchasing hospital-based services from the private sector, and private hospitals depended heavily on public financing. The government aimed to play an important role in health resources and services development planning, and in the regulation of the health sector. A new law on autonomy of public hospitals would allow the public hospitals to be better managed and enable services not only to complement the private hospitals but to compete as well, thus allowing better accessibility to quality health services. Competitive public hospitals would ideally serve as a reference for the Ministry of Public Health in analysing costs and setting quality standards, and would hopefully lessen the dependence on the private sector. No government budget would be allotted for public hospitals. The new law allowed for contracting with financing agencies, including the Ministry of Public Health, and reimbursement would be directly linked to productivity.

The Government was involved in health financing, with the purpose of ensuring universal health coverage, and undertook to cover anyone not covered by other insurance schemes. The Ministry of Public Health was now trying to make use of its role as the major financier in order to strengthen its regulatory role and promote reform. This would be done through contracts between financier and provider. There was, said Dr Ammar, an opportunity for reform opening up as pressure on public funds made the current system financially unviable and as diminishing returns and delays in reimbursement pushed the private sector to consider new alternatives and become receptive to the idea of change.

Reform of health sector financing was directed at overcoming fragmentation of public financing, which had been identified as a major cause of cost escalation of medical services. Private providers were dealing, through their associations, with each funding agency separately, which put them in a better bargaining position and allowing them to practically impose their terms. The merger of these funding agencies was desirable but difficult. However, there should at least be common ground for selecting providers and negotiating contracts based on the availability of relevant information. Any solution had to be administratively and politically feasible, and had to respect the independence of each funding agency. The creation of an interface between providers and funding agencies and of resource bodies to assist these agencies and execute on their behalf some technical tasks would be a feasible alternative.

Dr Ammar summarized the main reasons for private sector inefficiency as the lack of competitiveness in the health care market, institutional weaknesses of public financing agencies, fragmentation of public financing, and consumer perception of quality as requiring high technology and pharmaceuticals. The cornerstone of reform remained the reorientation of health expenditures towards more cost-effective alternatives, such as promotion and prevention programmes, integration of techniques and development of policies aiming at reducing hospitalization rate and length of stay, and encouraging outpatient services and home care.

The government was committed to the primary health care strategy to attain the goal of health for all and, to this end, had consolidated its traditional relations with nongovernmental organizations through contractual agreements for establishing a network of primary health care centres. The Ministry of Public Health provided essential drugs, medical supplies and technical assistance, while the nongovernmental organizations committed themselves to improving the health status of the population within a defined catchment area by delivering a comprehensive package of primary health care services. The contracts provided for the first time an official framework of accountability. Ministry assistance was directly linked to the proper implementation of programmes and their impact on the community's health status, rather than the increase in the number of patients as in the current approach. The Ministry had also sought to empower the periphery. The district health officer was considered the key person at the district level, while involvement of general practitioners and family physicians was also considered essential in the primary health care system.

The Minister of Public Health had launched the debate on health sector reform by issuing a draft paper for discussion. The national strategy for health reform and a plan of action would be elaborated following a consensus-building process. Meanwhile significant progress had already been achieved in, *inter alia*, institutional strengthening of the Ministry, restructuring of its budget, strengthening public hospitals, building-up capacity in health sector regulation, promoting competitiveness between health providers, expanding insurance coverage, developing the institutional capabilities of public financing agencies and overcoming fragmentation of financing.

Discussions

H.E. the Minister of Health of Saudi Arabia stated that the Saudi experience was different from that of the Lebanese. He noted that in Saudi Arabia private hospitals were usually established to alleviate the pressure on public hospitals. He said that private hospitals in Saudi Arabia were very successful and did not suffer from the bureaucracy that public hospitals suffered from.

Dr Ammar commented that as a result of the war, only private hospital services were available, but their costs were very high. There was a need for public hospitals in order to maintain the necessary balance, and the government must interfere to regulate the private health sector. The operation of regulating this sector was essential but complex.

The Minister of Health and Population of Egypt pointed out that in order to achieve high health cost-effectiveness, curative services should constitute 20% of government expenditure on health only, while preventive services should constitute 80%. He emphasized the importance of adhering to primary health care, whether it was provided by the public or the private sector. He noted that the immunization rates given in the presentation were not high enough, particularly since immunization was an important component of basic health care. He emphasized the importance of ensuring a minimum level of health care for the underprivileged, if real health reform was to be achieved. He added that the Egyptian experience was essentially different from that of Lebanon, where the private sector had overexpanded. There was thus a need to regulate that sector to achieve good balance. He advocated encouraging the establishment of various levels of private hospital so that not all private sector hospitals would be of very high standard.

The Representative of Jordan said that the Lebanese experience of 80% of the health budget being spent on 2% of the cases was not an unusual one. Public sector bureaucracy could contribute to such a situation as could uncontrolled purchase of medical services from the private sector by the government. However, the health systems and recent history of most countries of the Region differed from those of Lebanon. Thus the Lebanese example was perhaps an inappropriate model for others to follow. He called for the institution of mechanisms for pricing and negotiation between the public and private sectors for purchase of services, saying that governments still had a social role in maintaining quality of services and price control and ensuring the availability of health services to all sectors of society.

H.E. the Minister of Health of Saudi Arabia commented that uncontrolled expansion of any sector should not be permitted. He emphasized the importance of defining the regulatory role of the ministries of health in Member States and of deciding whether the focus of ministries should be on preventive, curative, health education or other aspects.

Dr Ammar acknowledged that the Lebanese experience was by no means ideal, as it was the by-product of severe circumstances. Health services were provided by the private sector because the public sector had been unable to provide these services adequately during the war. He added that the operation of health services regulation was more sophisticated than health service provision and required greater efficiency and potential.

The Representative of Oman said that WHO headquarters had published a useful study on essential public health functions, outlining the role of the state in the provision of most health service functions, such as immunization, primary health care, etc., and pointing out that even if the private sector could undertake some health services, it could not possibly meet all health needs at the national level. He called for an Arabic translation of this study.

The Representative of the United Arab Emirates enquired about the types of health services provided in Lebanon, irrespective of the sector providing them. He commented on the high prevalence rates for obesity in Lebanon, 50% for men and 75% for women, and the possible adverse health effects.

H.E. the Minister of Health of the Syrian Arab Republic said that despite the war circumstances, the health indicators in Lebanon were quite good. He emphasized the importance of the regulatory role of the state, as well as of human resource development in the field of health, and of re-emphasizing the role of the family doctor in medical education.

H.E. the Minister of Health of Saudi Arabia pointed to the need in the Region for all types of medical specialization, and the need to highlight the role of health economics and develop clear roles for ministries of health.

Dr Ammar said that immunization rates in Lebanon were quite high and that the Ministry of Public Health was largely responsible for immunization activities. However, the private sector provided around 50% of child immunization services upon personal initiatives. As for obesity, he said that most of people considered obese were only mildly so, although this overweight was still considered obesity according to WHO parameters. As for the role of the public health sector, it would be defined according to the dictates of the specific circumstances in every country. While the private sector played an important role, there was a need to define and regulate it to avoid problems.

The Representative of ACDIMA enquired whether there was in Lebanon a governmental body responsible for drug control that could intervene, as necessary, to specify drug prices and specifications.

Dr Ammar replied that the Department of Pharmacy, Ministry of Public Health, undertook this function.

The Regional Director commented that the issues raised were highly important, particularly those relating to the public/private health sectors and the role of the state in this connection. He said that the topic required a special two- or three-day meeting. He went on to say that, generally speaking, the private sector did not endeavour to serve remote and rural areas or to provide human resources development and training, as it did not find these activities cost-effective. Hence, the state had to undertake these functions. The private sector did not focus on prevention. It was necessary, he said, to study the specific circumstances of the Region and recognize how different they were from those prevailing in Europe or the United States of America. Attention should also focus on health economics,

health insurance and the provision of health care to the poor and rich, if possible charging fees to the rich for the public health services to alleviate some of the burden on the state.

The Regional Director emphasized that there was no ideal health system anywhere in the world and said that more than 44 million US citizens were not covered by health insurance, despite the availability of the most sophisticated health care—albeit very expensive—in the world, treatment costs being very high.

He added that Sri Lanka had submitted a study proving that its national health situation was superior to that in more advanced countries, the reason being the availability of many well trained nurses, an element much needed in the Eastern Mediterranean Region, as well as an emphasis on preventive measures.

The Chairman said that other major problems which must be addressed by the ministries of health were health economics, prevention, drugs, health ethics, training, research, etc.

The Representative of Bahrain said that the role of the ministry of health with regard to the private health sector should be basically legislative to prevent the overexpansion of that sector, and that the private health sector in Lebanon had grown immensely in the absence of appropriate legislation. He added that the ministry of health should also endeavour to strengthen primary health care.

7.3 Evaluation report of the Joint Government/WHO Programme Review Missions in 1997

Agenda item 9, Document EM/RC45/7, EM/RC45/R.11

This agenda item was introduced by Dr Anne Marie Worning, Regional Adviser, WHO Programme Development. The Joint Government/WHO Programme Review Missions (JPRMs) were introduced into the Eastern Mediterranean Region in 1984 and follow the WHO biennial planning cycle. Hence, the eighth round of JPRMs took place in the second half of 1997 for planning the 1998–1999 programmes of collaboration.

The JPRM planning exercise aims at reviewing national health policies and WHO collaborative programmes in a cohesive manner in order to draw up a plan for joint action. The plan must be in line with and support national priorities and strengthen national strategies for achieving health for all by the year 2000. The JPRM process is therefore cyclical and comprises three major functions: first, evaluation of the nearly completed biennium (1996–1997); secondly, detailed planning for forthcoming biennium (1998–1999); and last, mapping out the direction for the future, especially in relation to strategic planning for the biennium 2000–2001.

In order to fulfil the objectives of the JPRMs a number of preparatory steps have to be undertaken both at country level and in the Regional Office. By analysing these steps a number of areas have been identified where further efforts should be invested during the next round of JPRMs, and these are listed in the recommendations.

The eighth round of JPRMs took place between end July 1997 and early January 1998. Due to the prevailing situation in Afghanistan and Somalia, the WHO collaborative programmes in these countries could not be conducted as a joint effort with governments but were prepared by the Regional Office and the WHO Representatives in both countries.

All JPRMs were modified in February 1998 following the decision by the Director-General of WHO to establish the working allocation at 97% of the approved budget. In the Eastern Mediterranean Region the programme budget implementation reduction was not implemented by a proportionate cut but this opportunity was used to further streamline the JPRMs. Therefore all JPRMs were looked at individually and selected activities cancelled to make up the 3%.

In cancelling activities, care was taken to safeguard the priority areas as defined by the Executive Board and the Regional Committee; to primarily cancel activities scheduled for the last quarter of the biennium; to leave intact national training activities benefiting a large number of individuals; and to selectively cut expensive long-term fellowships for individuals and large supply and equipment components. The thus modified reports were finalized by 1 April 1998.

As a result of the lessons learned in previous rounds, the major improvement proposed for the ninth round will be the increased emphasis on evaluation.

Evaluation is an integral part of the work of WHO and is an essential element of any programme delivery. The need to strengthen evaluation has been the focus of a series of recent resolutions by the WHO governing bodies. A proposal for Organization-wide evaluation was recently issued, and on receipt of these guidelines the Regional Office immediately pilot-tested them in Oman.

This pilot exercise yielded important information, and the methodology proposed was found limited, especially with regard to evaluating the broader role and function of the WHO Representatives' offices. These observations will now be taken into account when planning how to strengthen the evaluation component of the JPRM for the next round.

Based on the conduct of the eighth round of the JPRMs it can be concluded that:

- The JPRM is a well established concept in the Eastern Mediterranean Region and it has been possible, over the biennia, to adapt the process to adjust to new managerial principles. However there is still scope for improvement, and further reorientation is needed.
- The evaluation aspect of the JPRMs should be strengthened, and any biennial implementation evaluation should be fully incorporated into the JPRM process.
- More emphasis has to be given to the definition of strategic priorities for future biennia, and the link between the programme budget and the JPRM plans of action has to be strengthened.

- The preparations prior to the actual mission should be improved, especially with regard to provision of specific briefings.
- The importance of the JPRM being a joint exercise requiring a high level of support and input from the ministries of health should be emphasized.
- The computer tool should be improved and made more user friendly. It should accommodate also Arabic and French.

Discussions

The Representative of Oman thanked the Regional Office and Member States for having selected his country for the pilot testing of the guidelines prepared for the evaluation of the Joint Government/WHO Programme Review Mission in the summer of 1998.

7.4 Healthy villages programme (special presentation)

Agenda item 11, Document EM/RC45/8

The item was presented by H.E. Dr Mohammed Eyad Chatty, Minister of Health, Syrian Arab Republic, who summarized the achievements made in the country within the framework of the self-reliance strategy. These achievements were in preventive medicine, curative medicine and emergency medicine, in addition to training and the pharmaceutical industry. They had led to increases in immunization coverage, decreases in maternal and child mortality and an increase in the number of baby-friendly hospitals in the country.

The aims of the healthy villages programme were to accelerate the attainment of health for all by the year 2000 and beyond, to strengthen local primary health care facilities, achieve comprehensive social development, based on citizen partnership and intersectoral collaboration. Among the components of the healthy villages programme were activities relating to the following areas: basic development needs, self-care, village information centres, baby-friendly hospitals, women's development, environmental promotion and safe motherhood. The programme has been implemented in the village of Akraba in the governorate of Dar'a.

A representative of a district in Jaba village in Quneitra governorate, Syrian Arab Republic, pointed out that the healthy villages programme played an essential role in responding to the basic requirements of development. She mentioned the duties assigned to district representatives and the different courses they had for training them in conducting health, social and economic surveys; home economics; development of skills; and the use of computers. She said that all the women in her village had been trained in self-care, received vocational training, given basic education and provided with health education.

A young Syrian villager described the environmentally, socially and culturally positive results of implementing the healthy village programme in his village. He described the important positive role played by the community school in his village, making students aware of the importance of preserving our planet and of turning arid pieces of land into

green areas, training students in different skills, including dealing with beehives, and raising their awareness of the dangers of smoking, which was not only a health problem but also a social and economic one.

Dr Mohsen Kanaa, the Executive Director of the Healthy Village Programme, Syrian Ministry of Health, presented some technical issues regarding the programme: criteria for selecting healthy villages; management of the programme; and the stages of implementing the programme in the Syrian Arab Republic. He dealt also with the positive results of implementing the programme, including the increase of health units in those villages.

The Chairman of the meeting expressed his appreciation for the presentation, hoping that the Syrian experience would be replicated in all villages in all countries of the Region.

7.5a) Draft regional health-for-all policy and strategy for the 21st century

Agenda item 15, Document EM/RC45/14, Resolution EM/RC45/R.4

The item was presented by Dr A. Saleh, Director, Health Policy and Management, who briefly outlined the background to the development of this draft document and of the regional contribution to the global document and outlined the main points of the document. The presentation concentrated on issues of pertinence to the Region. These included emphasis on the spiritual dimension in defining health and the right to health based on solid values of equity, ethics, social solidarity and cooperation, as well as emphasis on the role of women in promoting the health of the family, the community and the nation. They also included regional problems such as the relative weakness of national health systems, particularly with respect to policy analysis and formulation, strategic planning, the managerial process, health information systems and intersectoral cooperation; lack of community involvement; poor resource allocation; and poor working conditions of public employees. The presentation also emphasized the global challenges facing countries of the Region. These included political changes, the macroeconomic environment, globalization and global free trade, the global revolution in communications and advances in health technology, and environmental degradation.

Following a brief review of the regional situation, a number of strategic orientations were presented. These included commitment to health-for-all goals, development within a national health policy framework, development of a sustainable health system, primary health care as the key to achieving health for all, health as an integral component of overall development, health as a "bridge for peace", protection of a healthy environment, and promotion of healthy lifestyles.

Dr Saleh discussed the role of WHO, in particular at country level. He emphasized the fact that WHO comprised not only the technical secretariat but its Member States and Governing Bodies also; its fundamental role was to support national programmes. At country level, the WHO country office functions as an integral part of the national health system. All levels of WHO, he said, should work in full coordination to support Member States, and the views of Member States should be included in global documents.

Finally, Dr Saleh discussed the process proposed for consultation within the Region prior to finalization of the regional policy document and its presentation to the Forty-sixth Session of the Regional Committee.

Discussions

The Representative of the Islamic Republic of Iran said that the health-for-all policy was still a vital strategy, globally, regionally and nationally. He warned, however, that national averages may not give a clear picture of a country's health situation and analysis of data at provincial level or better, by rural or urban population, or by sex could identify at-risk groups not picked up at national level. He said that the private sector's role was important, but national authorities still had to set and maintain standards. The future of the health for all policy required firm political commitment. Mobilization of human resources was important, and that, coupled with development and acquisition of technology and committed leadership, could lead to regional self-reliance in production of biologicals and pharmaceuticals. The representative talked about social security and health insurance, saying that despite there being a compulsory health insurance scheme in the Islamic Republic of Iran, there had been difficulties of implementation in the low-income group. Consultative meetings organized by the Regional Office on this subject would enable experiences to be shared and problems to be addressed. The representative drew the Committee's attention to the Region's young population and mentioned the Islamic Republic of Iran's successful family planning programme, whose experiences the country would gladly share. He also reiterated the importance of quality of services and proposed to organize a consultation or task force to improve quality.

7.5b) World Bank health strategy

Agenda item 15

The item was presented by Dr George Schieber, Health Sector Leader, World Bank Middle East and North Africa Region. He gave an overview of the World Bank's health, nutrition and population sector strategy in general and for the Middle East and North Africa Region (MENA) in particular. The strategy focuses on: improving health, nutrition and population outcomes for the poor and protecting all individuals against the adverse consequences of illness; enhancing the performance of health care systems with respect to access, equity, efficiency and quality; securing sustainable financing in terms of resource mobilization; risk pooling and controlling public and private health expenditures. He then focused his presentation on the health care financing and delivery issues for the MENA region. He discussed the importance of ownership and collaboration with WHO and other relevant partners.

In this regional focus, Dr Schieber described the health situation, health financing and expenditure patterns, health delivery systems and the health reform agenda. Much of the presentation focused on health expenditure patterns in the region and worldwide, and Dr Schieber stressed the need for national health accounts, given the poor state of health expenditure information in most countries, particularly for private spending.

Concerning the MENA health reform agenda, Dr Schieber discussed reforms in six areas: policy-making and the need for data for decision-making; reforms in the public health area; reforms in health care financing, particularly revenue raising, risk pooling, and provision and regulation of public and private insurance; reforms of the human and physical health care financing and delivery systems; reforming medical care provider payment; and reforming the pharmaceutical sector.

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

Agenda item 16(a), Document EM/RC45/15, Decision 5

The Regional Committee nominated the Islamic Republic of Iran to serve on the Management Advisory Committee of the Action Programme on Essential Drugs for a three-year term from 1 January 1999 to 31 December 2001.

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

Agenda item 16(b), Document EM/RC45/16, Decision 4

The Regional Committee nominated Oman to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three-year period from 1 January 1999 to 31 December 2001.

7.8 Subjects for technical discussions and technical papers in 1999 and 2000

Agenda item 17, Document EM/RC45/17

The item was presented by Dr Anne Marie Worning, Regional Adviser, WHO Programme Development, to prioritize the subjects for technical discussions and technical papers proposed for the years 1999 and 2000, so as to discuss in the first year the most important subjects and in the second year the remaining subjects. Members of the Regional Committee could, if they wished, leave the task of prioritization to the Regional Office.

The Representative of Saudi Arabia proposed that the task of prioritization be left to the Consultative Committee.

The Representative of Egypt proposed that priority should be given to the subject of health economics and related subjects such as financing health services and health insurance, as this was a topical subject in many countries of the Region.

The Representative of the United Arab Emirates supported the proposal made by the Representative of Egypt.

7.9 Down syndrome—establishment of a regional research prize foundation

Agenda item 18, Document EM/RC45/18, Resolution EM/RC45/R.9

Mr T.H. Mirza, Director, Administration and Finance, presented the establishment of a regional foundation prize for research on Down syndrome. He requested the Regional Committee to approve the text of the statutes of the Down Syndrome Research Prize Foundation which had been endorsed by the Regional Consultative Committee.

The Representative of Oman, on behalf of the Regional Committee, thanked Dr Abdel Rahman Abdulla Al-Awadi for his generous donation to establish the prize and hoped that others would follow this example.

7.10 Revision of the International Health Regulations

Agenda item 19, Document EM/RC45/19

Dr Mohammed Helmy Wahdan, Assistant Regional Director, presented this item. He said that the revision of the International Health Regulations had been triggered by the Regional Committee for the Eastern Mediterranean during its Forty-first Meeting in Bahrain at the time of the plague epidemic in 1994.

The International Health Regulations are needed to standardize procedures to be taken by all countries to ensure maximum security against the international spread of diseases with minimal interference with world traffic.

Dr Wahdan highlighted the main shortcomings of the present International Health Regulations. They relate to only three diseases—plague, cholera and yellow fever and have been largely ineffective. In addition, there are many more diseases of international significance that can and have caused epidemics and require standardized procedures to be practised by all countries.

Most provisions regarding notification of epidemiological information are not followed, by most Member States. Affected countries remain silent or officially deny outbreaks of diseases subject to the International Health Regulations. One of the possible reasons is that national authorities are concerned about measures taken against them that are more stringent than those prescribed by the International Health Regulations, and there is nothing in the Regulations that can help countries to counter these measures. Lack of trust and cooperation between countries is one reason for these excessive measures. As well, inadequate action against disease outbreaks, including incomplete implementation of the relevant articles of the International Health Regulations, invites other countries to apply their own measures.

Dr Wahdan then described the main changes in the draft revised International Health Regulations. They broaden the number of diseases covered by the International Health Regulations and theoretically promote early reporting of syndromes without waiting for confirmation of diagnosis. The revised Regulations are limited to general principles while

technical details are left to annexes which can be updated as frequently as necessary without having to go through long procedures.

It was indicated that the revised Regulations are not expected to solve some of the basic reasons for noncompliance, particularly hesitation to report for fear of action imposed by other countries. The lack of trust and cooperation between countries will not be solved by the modifications as there are no provisions against countries that impose excessive measures. In this regard it is a priority to reach an agreement with the World Trade Organization (WTO) on the application of sanitary and phytosanitary measures, since the WTO is empowered to take action against WTO member states not adhering to the agreements it oversees.

Dr Wahdan concluded by stating that the main principle should be not only to have updated regulations but to have functional ones. It is, therefore, essential that all countries, and in particular those who hesitate to abide by the articles on notification, give their views on the revised International Health Regulations and on how they can be modified to overcome their fears.

Discussions

The Representative of Oman said that syndromic reporting should only relate to the numbers of cases of infection detected, not to nationalities.

7.11 Award of Dr A.T. Shousha Foundation Prize

Agenda item 20, Document EM/RC45/Inf.Doc. 1

The Chairman presented the Dr A.T. Shousha Foundation Prize for the year 1998 to Dr Awad Hussein Abudejaja (Libyan Arab Jamahiriya), in accordance with the decision adopted by the Executive Board at its 101st session, for his outstanding contribution to health promotion in the geographical area in which Dr Shousha served the World Health Organization.

7.12 Place and date of the next Session of the Regional Committee

Agenda item 21, Document EM/RC45/Inf.Doc. 2, EM/RC45/R.13

The Regional Director announced that 16 countries of the Region, a majority, had requested that the date of the Regional Committee meeting be advanced to the last week of September, instead of the first week of October.

The Minister of Health and Population of Egypt extended an invitation to the Regional Committee to hold its next Session in Egypt.

The Regional Director said that he had also received an invitation from the Republic of Yemen to hold the next Regional Committee in that country.

8. CLOSING SESSION

8.1 Review of draft resolutions, decisions and report

Agenda item 22(a)

In the closing session, the Regional Committee reviewed the draft resolutions and decisions. Some changes to the drafts were proposed and accepted.

8.2 Adoption of resolutions and report

Agenda item 22(b)

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

8.3 Closing of the Session

Agenda item 23, Decision 6

The Regional Committee decided to send a telegram to H.E. President Elias Hraoui, extending its deep gratitude for having honoured the opening session with his presence and for placing the Forty-fifth Session of the Regional Committee under his kind patronage, wishing him good health and happiness.

It also extended its thanks to H.E. Mr Sleiman Frangieh, the Minister of Public Health, and expressed its appreciation for all the excellent facilities offered by him and the staff of the Ministry of Public Health, which contributed to the success of the Session, praying to God Almighty to give him good health and bestow on Lebanon further stability and prosperity.

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

9. RESOLUTIONS AND DECISIONS

The following resolutions and decisions were adopted by the Forty-fifth Session of the Regional Committee for the Eastern Mediterranean (Resolutions EM/RC45/R.1-13 and Decisions 1-6).

9.1 Resolutions

EM/RC45/R.1

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 1997¹ and having noted his statement thereon;

1. **THANKS** the Regional Director for his comprehensive report, which highlights the close cooperation between the Regional Office and the Member States and reflects the significant achievements made through WHO collaborative efforts with Member States in the Region;
2. **ADOPTS** the Annual Report of the Regional Director;
3. **ACKNOWLEDGES** the community-based health development initiatives taken by the Regional Office;
4. **CALLS FOR** the provision of all possible support to the Mediterranean Centre for Vulnerability Reduction;
5. **EMPHASIZES** the necessity of private medical schools meeting the required criteria and of their establishment being in accordance with the national human resources development plan;
6. **ENDORSES** the decision of the Regional Director to cease deducting from country budgets the percentage allocated for the health leadership development programme as from the next biennium;
7. **AGREES** to transfer a part of the percentage allocated to the Regional Centre for Environmental Health Activities (CEHA) to health economics;
8. **REAFFIRMS** the need for continued national commitment to timely eradication of poliomyelitis, including continued conduct of national immunization days and strengthening of acute flaccid paralysis surveillance systems.

¹ Document EM/RC45/2

EM/RC45/R.2

**PROPOSED PROGRAMME BUDGET FOR THE
EASTERN MEDITERRANEAN REGION FOR THE
FINANCIAL PERIOD 2000–2001**

The Regional Committee,

Having considered the proposed programme budget for the Eastern Mediterranean Region for the Financial Period 2000–2001¹;

Noting that the proposed programme budget conforms to the Ninth General Programme of Work and the Regional Programme Budget Policy and reflects national and regional priorities;

Taking into consideration the budgetary reduction caused by the use of the mathematical model adopted by the World Health Assembly in resolution WHA51.31;

1. **EXPRESSES** serious concern at the impact of implementing resolution WHA51.31, adopted by the Fifty-first World Health Assembly, on the Eastern Mediterranean Region programme for the biennium 2000–2001 and future biennia;
2. **REQUESTS** the Director-General to:
 - 2.1 Take action, through the use of extrabudgetary resources, transfers from WHO headquarters as mandated by resolution WHA48.26, and casual income, to reduce the impact of the application of the adopted model and thereby compensate for cuts from the regional regular budget;
 - 2.2 Ensure that the percentage reductions to the budget applied over each biennium are equal for all regions;
3. **INVITES** Member States of the Region to make voluntary contributions, to the extent of their respective capacities, to increase regional extrabudgetary resources;
4. **REQUESTS** the Regional Director to transmit the proposed programme budget for the Eastern Mediterranean Region, as contained in document EM/RC45/3, to the Director-General for inclusion in her proposed budget for the financial period 2000–2001.

¹ Document EM/RC45/3

EM/RC45/R.3

**EMERGING AND RESURGING DISEASES IN THE
EASTERN MEDITERRANEAN REGION WITH SPECIAL
REFERENCE TO MALARIA**

The Regional Committee,

Having reviewed the technical paper on emerging and resurgant diseases in the Eastern Mediterranean Region, with special reference to malaria¹;

Recalling resolution EM/RC43/R.14 on a regional strategic plan in response to emerging and re-emerging diseases and resolution EM/RC40/R.10 on malaria control;

Concerned about the potential hazards from emerging and re-emerging diseases;

Recognizing the epidemic potential of malaria in countries with the afrotropical type of the disease and the potential threat of re-establishing malaria endemicity in areas where transmission has been interrupted;

Acknowledging the global initiative of Roll Back Malaria and expressing its hope that the initiative will provide substantive support to national malaria control programmes in the Region;

1. **THANKS** the Regional Director for his report;
2. **URGES** all Member States to:
 - 2.1 Continue strengthening their epidemiological surveillance of infectious diseases and their capabilities to respond to the emergence of these diseases in line with the regional plan on emerging and re-emerging diseases;
 - 2.2 Promote cooperation with neighbouring countries in surveillance and prevention and control of imported infectious diseases;
 - 2.3 Promote applied research related to emerging infectious diseases including malaria;
3. **URGES** Member States with the afrotropical type of malaria to:
 - 3.1 Strengthen national capabilities in early diagnosis, case management, forecasting and prevention and control of malaria epidemics;
 - 3.2 Promote the use of personal protection measures, especially the use of protective insecticide-impregnated materials;

¹ Document EM/RC45/9

4. **URGES** Member States that have achieved interruption of malaria transmission to:
 - 4.1 Continue to identify and control any re-introduction of the disease at an early stage;
 - 4.2 Support activities towards malaria eradication in areas where it is feasible;
5. **REQUESTS** the Regional Director to report regularly to the Regional Committee on progress made in the prevention and control of emerging and re-emerging diseases with special reference to malaria.

EM/RC45/R.4 **DRAFT REGIONAL HEALTH-FOR-ALL POLICY AND STRATEGY FOR THE 21st CENTURY**

The Regional Committee,

Having considered the draft document on the regional health-for-all policy and strategy for the 21st century¹;

Recalling resolutions WHA48.16 on WHO's response to global change: renewal of the health-for-all strategy and EM/RC44/R.7 on health for all in the 21st century;

Noting that Member States are undergoing health sector reform;

Reaffirming the importance of taking into account the sociocultural characteristics of the Region;

1. **CALLS UPON** Member States to:
 - 1.1 Continue their active participation in the regional consultation process leading to finalization of the regional document;
 - 1.2 Exchange information on country experiences and collaborate with each other in the process of renewal of national health-for-all policy for the 21st century;
 - 1.3 Strengthen national capacity in the areas of health policy formulation, strategic planning, health economics and health care financing;
 - 1.4 Sustain political, management and financial commitment to ensuring the sustainability of an effective health system based on primary health care;

¹ Document EM/RC45/14

2. **REQUESTS** the Regional Director to:
 - 2.1 Continue and expand the regional consultation process and consider organizing a regional conference in this regard;
 - 2.2 Initiate the process of developing detailed strategies for health-for-all policy for the 21st century;
 - 2.3 Present the revised document to the Forty-sixth Session of the Regional Committee for the Eastern Mediterranean for approval.

EM/RC45/R.5

**REGIONAL SELF-RELIANCE IN THE PRODUCTION OF
ESSENTIAL DRUGS AND VACCINES**

The Regional Committee,

Having considered the current situation relating to the local production of essential drugs and vaccines outlined in the technical discussions paper¹;

Deeply concerned about the suffering of the peoples of some countries of the Region as a result of actions that impede self-sufficiency in essential drugs and vaccines for those countries;

Recognizing the challenges faced in promoting self-reliance in production of essential drugs and vaccines;

1. **URGES** Member States to:
 - 1.1 Collect reliable data on national needs with regard to drugs and vaccines, and their consumption and production patterns, with special emphasis on essential drugs and vaccines;
 - 1.2 Develop strategies for ensuring the availability of drugs and vaccines of high quality through importation or high quality local production;
 - 1.3 Strengthen national capacities for the control of drugs and vaccines, including establishing functional national control authorities where these have not yet been established;
 - 1.4 Establish coordination and collaboration in quality assurance, research and development, and in essential drugs and vaccine production, foster the development of common policies in relation to self-reliance in essential drugs

¹ Document EM/RC45/Tech.Disc. 1

and vaccines through regional and subregional structures or networks and promote regional trade;

2. **REQUESTS** the Regional Director to:

- 2.1 Support countries in updating their national pharmaceutical legislation by elaborating technical guidelines for current good manufacturing practices (cGMP) requirements;
- 2.2 Strengthen intercountry collaboration in harmonizing regulations and standards for quality requirements in order to promote regional trade of essential drugs;
- 2.3 Act for the removal of all impediments that restrict their ability to utilize their resources and capacities for promoting local industries of essential drugs and vaccines.

EM/RC45/R.6

**ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
IN THE EASTERN MEDITERRANEAN REGION**

The Regional Committee,

Having reviewed the progress report on acquired immunodeficiency syndrome (AIDS) in the Eastern Mediterranean Region¹;

Considering the increasing spread of the human immunodeficiency virus (HIV) infection in the Region;

Noting the developments in treatment of AIDS and in prevention of mother-to-child transmission of HIV;

Recognizing the role of sexually transmitted diseases (STD) in transmission of HIV infection;

Appreciating the efforts made by national authorities in prevention and control of AIDS and STD;

1. **THANKS** the Regional Director for his report and for his continued technical and financial support provided to the Member States;

¹ Document EM/RC45/12

2. **URGES** Member States to:

- 2.1 Continue to provide strong political commitment to the fight against AIDS and to allocate adequate resources for strengthening prevention efforts and to encourage the active involvement of all sectors and nongovernmental organizations concerned;
- 2.2 Continue to fight denial and complacency and avoid any form of stigmatization and discrimination against HIV-infected persons;
- 2.3 Take effective steps to prevent and treat STD;
- 2.4 Continue to monitor HIV/AIDS and STD prevalence and to provide the Regional Office with complete and regular reports on them;

3. **CALLS UPON** UNAIDS to further strengthen its collaborative efforts in the Region in preventing the spread of infection and in other control areas;

4. **REQUESTS** the Regional Director to:

- 4.1 Provide technical and financial support to the Member States in planning, implementing, monitoring and evaluating national programmes for the control of AIDS;
- 4.2 Inform the Regional Committee about the status of the AIDS epidemic and of progress in the efforts to fight it.

EM/RC45/R.7

PREVENTION AND CONTROL OF CARDIOVASCULAR DISEASES

The Regional Committee,

Having discussed the technical paper on prevention and control of cardiovascular diseases¹;

Recognizing the considerable magnitude of these diseases which are a leading cause of morbidity and mortality in the Region;

Mindful of the significant burden on public health services resulting from the commonly encountered cardiovascular diseases, notably hypertension, coronary heart disease, stroke and rheumatic heart disease, and the rising economic costs that they provoke in Member States;

¹ Document EM/RC45/10

Aware of the pressing need to intensify efforts to prevent these diseases, to detect them early, to provide appropriate care and to prevent complications and premature death for those with established disease;

1. **URGES** Member States to:

- 1.1 Establish, if they have not already done so, national programmes for the prevention and control of cardiovascular diseases that cover activities for all levels of prevention and involve nongovernmental organizations and national societies in these programmes;
- 1.2 Establish community-based demonstration programmes on the primary prevention of cardiovascular diseases focusing on promotion of healthy lifestyles, especially prevention of obesity, smoking control and promotion of physical activity;
- 1.3 Provide the essential elements of health care for people with cardiovascular diseases at all levels of the health care system, placing particular emphasis on integrating such care into primary health care;

2. **REQUESTS** the Regional Director to:

- 2.1 Continue to provide technical support to national programmes for the prevention and control of cardiovascular diseases, particularly in relation to primary prevention, and to facilitate the development of a regional network for community-based intervention programmes for the primary prevention of these diseases;
- 2.2 Submit a follow-up report to the Regional Committee on progress achieved.

EM/RC45/R.8

**THE REGIONAL CONSULTATIVE COMMITTEE
(TWENTY-SECOND MEETING)**

The Regional Committee,

Having considered the report of the twenty-second meeting of the Regional Consultative Committee¹;

Acknowledging the need to give special attention to health in border areas, particularly in relation to disease prevention, control and elimination/eradication;

¹ Document EM/RC45/5

1. **ENDORSES** the report of the Regional Consultative Committee, taking into account the comments of the Regional Committee;
2. **COMMENDS** the support provided by the Regional Consultative Committee;
3. **CALLS UPON** Member States to implement the recommendations included in the report, as appropriate;
4. **REQUESTS** the Regional Director to implement the recommendations in the report that require WHO input, with special emphasis on control of communicable diseases in border areas.

EM/RC45/R.9

**DOWN SYNDROME—ESTABLISHMENT OF A
REGIONAL RESEARCH PRIZE FOUNDATION**

The Regional Committee,

Having reviewed the Regional Director's report on Down Syndrome¹;

Recalling its endorsement of the Regional Consultative Committee's proposal to agree to the establishment of prizes for research on priority problems in the Region;

Taking into consideration the high incidence of Down Syndrome in countries of the Eastern Mediterranean Region;

1. **PROPOSES** the establishment of a regional foundation prize for research into Down syndrome;
2. **CONVEYS** its appreciation to Dr Abdel Rahman Abdulla Al-Awadi for the generous offer of funds to be used to initiate this prize;
3. **APPROVES** the text of the Statutes of the Down Syndrome Research Prize Foundation in the Eastern Mediterranean Region;
4. **RECOMMENDS** the establishment of such a Foundation to the 103rd session of the Executive Board to be held in January 1999;
5. **INVITES** Member States, institutions and individuals to make voluntary financial contributions to WHO in order to increase the funds available to the Foundation for the award of such a prize.

¹ Document EM/RC45/18

EM/RC45/R.10

GATT AGREEMENT—ITS IMPACT ON HEALTH

The Regional Committee,

Having discussed the technical paper on the GATT Agreement and its impact on health¹;

Noting the concern expressed in recent summit meetings of developing and non-aligned countries and the Regional Committee for the Eastern Mediterranean of the possible impact of globalization and World Trade Organization agreements on the socioeconomic sectors in developing countries;

Noting the efforts of some Member States to make the best use of the transition period to prepare the national system for the full implementation of World Trade Organization agreements;

Appreciating the efforts made by WHO to publish information on the impact of WTO agreements on the health sector;

1. **URGES** Member States to:

- 1.1 Ensure that ministries of health are represented on national committees entrusted with the task of studying the negative impact of World Trade Organization agreements on the health sector;
- 1.2 Conduct studies to coordinate response to World Trade Organization health-related agreements in cooperation with the Regional Office.

2. **REQUESTS** the Director-General to:

- 2.1 Continue, and expand upon, the ongoing studies on the impact of World Trade Organization agreements on the health sector, inviting contributions from Member States, and widely distribute the outcome of the studies;
- 2.2 Continue to promote WHO's role as the international agency responsible for setting standards in the health field;
- 2.3 Make constructive efforts with bodies and institutions concerned in order that they might take into account the social and health aspects of the impact of the World Trade Organization agreements;

¹ Document EM/RC45/11

3. **REQUESTS** the Regional Director to support the Ministries of Health in their efforts to address the negative impact of World Trade Organization agreements on the health sector, and act for the development of a regional plan for addressing this impact.

EM/RC45/R.11

**EVALUATION REPORT OF THE JOINT GOVERNMENT/
WHO PROGRAMME REVIEW MISSIONS IN 1997**

The Regional Committee,

Having considered the report of the Regional Director on the Joint Government/ WHO Programme Review Missions for the biennium 1998–1999 carried out during 1997¹;

1. **REAFFIRMS** the current Joint Programme Review Missions concept with its definition of measurable targets that respond to national priorities and the delivery of tangible products through well defined activities;
2. **THANKS** the Regional Director, the representatives of national authorities and WHO staff involved in Joint Programme Review Missions;
3. **URGES** Member States to support fully each round of the Joint Programme Review Missions by:
 - 3.1 Conducting comprehensive evaluations of national health programmes, including WHO-supported activities;
 - 3.2 Preparing full briefings about national health priorities, facilitating factors and constraints;
4. **REQUESTS** the Regional Director to continue the efforts to streamline the Joint Programme Review Mission process with special emphasis on strengthening the elements of evaluation and priority setting.

EM/RC45/R.12

**IMPROVING THE QUALITY OF NURSING AND
MIDWIFERY IN THE EASTERN MEDITERRANEAN
REGION**

The Regional Committee,

Having reviewed the Regional Director's report on progress with regard to Regional Committee resolution EM/RC41/R.10 on the need for national planning for nursing and midwifery in the Eastern Mediterranean Region¹;

¹ Document EM/RC45/7

Noting the progress made by Member States and the challenges facing policy-makers and nurses in improving the quality of nursing and midwifery services;

Recognizing the potential of quality nursing and midwifery personnel in making a difference in health care services and people's quality of life;

1. **THANKS** the Regional Director for his progress report and for the increased support to nursing and midwifery in Member States;
2. **ADOPTS** the regional strategy on nursing and midwifery;
3. **URGES** Member States to:
 - 3.1 Continue their efforts to develop national action plans for the implementation of this strategy;
 - 3.2 Develop national standards for basic and graduate nursing education;
 - 3.3 Use the guidelines on future directions for nursing education in developing curricula;
 - 3.4 Encourage and support the development of programmes for nursing research to ensure that the practice of nursing is founded on scientific findings.

EM/RC45/R.13 **PLACE AND DATE OF THE NEXT SESSION OF THE
REGIONAL COMMITTEE**

The Regional Committee,

1. **THANKS** the Government of Egypt for its offer to hold its Forty-sixth Session in Egypt;
2. **REQUESTS** the Regional Director to consider holding the next Session in the last week of September.

¹ Document EM/RC45/13

9.2 Decisions

DECISION 1

ELECTION OF OFFICERS

The Regional Committee elected the following officers:

Chairman:	H.E. Mr Sleiman Frangieh (Lebanon)
First Vice-Chairman:	H.E. Dr El-Hédi M'henni (Tunisia)
Second Vice-Chairman:	H.E. Dr Abdallah Abd El Waly Nasher (Republic of Yemen)

Dr Wagida Abdel Rahman Anwar (Egypt) was elected Chairman of the Technical Discussions and Dr Mabruka Legnain (Libyan Arab Jamahiriya) co-Chairman.

The Regional Committee decided that the following should constitute the Drafting Committee:

Dr Ali Bin Jaffar Bin Mohammed Suleiman (Oman)
Dr Moncef Sidhom (Tunisia)
Mr Ismail Akbari (Bahrain)
Dr Mohammad Helmy Wahdan (EMRO)
Dr Abdel Aziz Saleh (EMRO)
Mr Hassan Naguib Abdalla (EMRO)

DECISION 2

ADOPTION OF THE AGENDA

The Regional Committee adopted the agenda of its Forty-fifth Session.

DECISION 3

NOMINATIONS OF REPRESENTATIVES FROM THE EASTERN MEDITERRANEAN TO THE SUBGROUP OF THE AD HOC WORKING GROUP ON THE REVISED DRUG STRATEGY

The Regional Committee nominated the Islamic Republic of Iran and the Republic of Yemen to serve on the subgroup of the Ad Hoc Working Group on the Revised Drug Strategy.

DECISION 4

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

The Regional Committee nominated Oman to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three-year period from 1 January 1999 to 31 December 2001.

DECISION 5

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

The Regional Committee nominated the Islamic Republic of Iran to serve on the Management Advisory Committee of the Action Programme on Essential Drugs for a three-year term from 1 January 1999 to 31 December 2001.

DECISION 6

CLOSING OF THE SESSION

The Regional Committee decided to send a telegram to H.E. President Elias Hraoui, extending its deep gratitude for having honoured the opening session with his presence and for placing the Forty-fifth Session of the Regional Committee under his kind patronage, wishing him good health and happiness.

It also extended its thanks to H.E. Mr Sleiman Frangieh, the Minister of Public Health, and expressed its appreciation for all the excellent facilities offered by him and the staff of the Ministry of Public Health, which contributed to the success of the Session, praying to God Almighty to give him good health and bestow on Lebanon further stability and prosperity.

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

Annex 1

AGENDA

1. Opening of the Session
2. Election of officers
3. Adoption of the agenda EM/RC45/1 Rev.1
4. The work of the World Health Organization in the Eastern Mediterranean Region—annual report of the Regional Director for the year 1997 EM/RC45/2
5. Proposed programme budget for the Eastern Mediterranean Region for the financial period 2000–2001 EM/RC45/3
6. Resolutions and decisions of regional interest adopted by the Fifty-first World Health Assembly and by the Executive Board at its 101st and 102nd Sessions:
 - (a) Regional allocations EM/RC45/4(a)
 - (b) Other resolutions EM/RC45/4(b)
 - (c) Nominations of representatives from the Eastern Mediterranean to the subgroup of the Ad Hoc Working Group on the Revised Drug Strategy EM/RC45/4(c)
 - (d) Review of the draft provisional agendas of EB103 and WHA52 EM/RC45/4(d)
7. Report of the Regional Consultative Committee (twenty-second meeting) EM/RC45/5
8. The role of private and public sectors in the national health care delivery system in Lebanon: reform proposals (*special presentation*) EM/RC45/6
9. Evaluation report of the Joint Government/WHO Programme Review Missions in 1997 EM/RC45/7
10. Technical discussions:
 - Regional self-sufficiency in vaccine and drug production EM/RC45/Tech.Disc. 1
11. Healthy Villages programme (*special presentation*) EM/RC45/8
12. Technical papers:
 - (a) Emerging and resurging diseases in the EMR with special reference to malaria EM/RC45/9
 - (b) Cardiovascular diseases prevention and control EM/RC45/10
 - (c) GATT Agreement—its impact on health EM/RC45/11

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| 13. | Acquired immunodeficiency syndrome (AIDS) in the EMR— <i>progress report</i> | EM/RC45/12 |
| 14. | Development in nursing and midwifery— <i>progress report</i> | EM/RC45/13 |
| 15. | Draft regional health-for-all policy and strategy for the twenty-first century (including a presentation on the World Bank health strategy) | EM/RC45/14 |
| 16. | Nominations:
(a) Nomination of a Member State to the Management Advisory Committee (MAC) of the Action Programme on Essential Drugs
(b) Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases | EM/RC45/15
EM/RC45/16 |
| 17. | Subjects for technical discussions and technical papers in 1999 and 2000 | EM/RC45/17 |
| 18. | Down syndrome—establishment of a regional research prize foundation | EM/RC45/18 |
| 19. | Revision of the International Health Regulations (information document) | EM/RC45/19 |
| 20. | Award of Dr A.T. Shousha Foundation Prize | EM/RC45/Inf.Doc. 1 |
| 21. | Place and date of future sessions of the Regional Committee | EM/RC45/Inf.Doc. 2 |
| 22. | Other business | |
| 23. | Closing session | |

Annex 2**LIST OF REPRESENTATIVES, ALTERNATIVES AND ADVISERS OF MEMBER STATES AND OBSERVERS****AFGHANISTAN**

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Ministry of Health and Population
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Adviser Dr Ahmed Badran
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Annex 3

**ADDRESS BY DR HUSSEIN A. GEZAIRY, WHO REGIONAL DIRECTOR FOR
THE EASTERN MEDITERRANEAN
to the
FORTY-FIFTH SESSION OF THE REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN**

Beirut, Lebanon, 3-6 October 1998

I am particularly pleased to see this Forty-fifth session of the Regional Committee for the Eastern Mediterranean being held in this country, so famous for its hospitality. I would like also to express my gratitude to President Elias Hraoui for honouring us with his presence, and for personally inaugurating this session. And may I add a prayer that Lebanon may enjoy ever greater stability, prosperity and happiness.

The Regional Committee is particularly delighted to welcome Dr Gro Harlem Brundtland, the new Director-General who is attending with us for the first time since her election. She will undoubtedly note some of the special characteristics of our Region which bring its countries together, notwithstanding its vast area and ethnic differences between its peoples. These characteristics tend to serve the cause of health and to make health work more fruitful. I am referring here to characteristics derived from inherent values in its culture, which is based on Islam and Christianity, the two great religions in which the overwhelming majority of the peoples of this Region believe.

The family in our Region is closely knit, and its bond is firm indeed. From the Eastern Mediterranean cultural perspective, the family is the nucleus of society and its basic unit. The values that prevail in this Region establish ties of mutual compassion, love and solidarity throughout society. The same ties form the underlying basis of family relationships. A married couple establish a bond of love and mutual kindness, and they both take good care of their children, giving them sound upbringing, and providing them with all types and aspects of care, which essentially includes health care. When children grow up they know that they must be dutiful to their parents, giving them all the love, compassion and care they can provide.

As health is our special field of interest, and it is from our perspective an essential human right, we find the strong family ties in this Region highly useful in facilitating our health work. If we recall the theme of this year's World Health Day, we find that it emphasizes the importance of mothers' health. Let us now remember that God has placed heaven under the feet of the mother, and set dutifulness to one's mother precedent over all obligations of care and help. It is most important to make use of such feelings of love and dutifulness to make all people aware of the need to take special care of women's health, right from their childhood, in order to ensure that when a woman is ready to become a mother, her pregnancy is safe.

Let us now look forward to the theme of next year's World Health Day, which concentrates on the health of the elderly. The cultural values that prevail throughout this Region lay special emphasis on showing genuine respect for elderly people and taking good care of them. In the words of an old Arabic saying, "a person who does not respect our elderly people and give them their due measure of love and care does not belong to us". If old people's homes are relatively few in number in our Region, this is due to the fact that we consider the natural place for the elderly to be with their families. It has been inculcated in us since our childhood that with old age comes mature vision and wisdom which we would do well to make use of. This ties in well with what the World Health Organization advocates in making use of the expertise of elderly people as we provide them with the care they need.

It may be useful to provide a practical example of how such values work in practice. The setting is our host country. During the Lebanese civil war, which we pray we will never see again, a natural and automatic complementarity took place between two neighbouring institutions: an orphanage and an old people's home. The managers of both institutions agreed that the elderly people should help in looking after the young ones in the orphanage. It was a highly enlightening experience. The children gave back the elderly a sense of purpose which they had lost. The old people looked forward impatiently to each new morning, so that they might proceed again to the orphanage to take care of their charges and enjoy their company. The young orphans were no less happy with the renewed meeting, receiving inexhaustible care, education and tips that could be highly useful in practical life.

Thus the life of these elderly people regained its meaning as they realized that they were doing something particularly useful that filled up their previously monotonous days. The young ones learnt from their patient and good-natured companions how to acquire good manners and to observe sound moral values. It is in such beneficial and innovative ideas that we in this Region take pride. For it is an idea that relies heavily on the values that prevail in our communities.

May I at this juncture suggest that we give due consideration to another concept that fits in perfectly with the values and ideals of this Region, namely, the adoption of elderly people into families. As we promote the notion of placing homeless children with families which may take care of their upbringing, and provide them with the chance of growing up in a natural family environment, we may apply the same idea to elderly people who have no families, so that they may live within a natural family environment. They would receive good care from the families who adopt them, so to speak. The adopting family will also gain from the experience, wisdom and advice of their new elderly members. This is a concept that we may like to try, particularly at this stage in human history which has witnessed a substantial increase in life expectancy and an unprecedented increase in the numbers of elderly people.

A great advantage of the characteristically closely knit family in the communities of the Eastern Mediterranean Region is that it has prevented the spread of some diseases. We

have, for example, a much better AIDS situation than other regions. The disease made a later appearance here and has remained at a much lower rate of incidence. In fact the number of people with HIV/AIDS in this Region is estimated at less than one per cent of the total global figure, while our population stands at eight per cent of all people in the world. For this privileged situation we are undoubtedly indebted to the moral and religious values that prevail in our Region, to the closely knit family, and the prevalence of faithful marriage. This does not mean that the practices which help the spread of AIDS, including high-risk sexual practices and intravenous drug injection are nonexistent in our Member States. They do exist in varying degrees, albeit on an overall limited scale. This favourable position must not be allowed to induce an air of complacency in our attitude to AIDS. In fact we need to look at these practices with all seriousness and we must mobilize our resources to keep them in check and to reduce their effects. In fact, the low rate of AIDS incidence in our Region, coupled with the presence of the practices that lead to its spread, mean that this is precisely the proper time for serious action which aims at the containment of this persistent disease and preventing its spread.

May I emphasize in this connection the advantages of early marriage. Providing the physical and mental growth of the young couple has been completed, and provided early marriage is coupled with strict family planning, it is the natural and healthy alternative to the premature sexual relationships that take place in many countries of the world today. Early marriage provides an appropriate means of satisfying the natural sexual urge in a manner that is both legitimate and that promotes the physical and mental health of young men and women. We should work towards removing the obstacles that impede early marriage, and eliminating useless customs that put false appearances above serving the interests of young people and the whole community.

You are well aware that breastfeeding is the normal practice in our Region. It is readily accepted by parents, as it represents a cultural value that is well entrenched in the family structure in this Region. However, some alien customs have begun to penetrate into our social set-up along with alien lifestyles. These try to persuade mothers to resort to alternative feeding, paying no regard to the fact that breastfeeding is highly beneficial to both mother and baby. Today we are trying hard to get rid of such alien customs and to re-establish our age-old values which make breastfeeding the cornerstone of motherly care of young babies. May I note with gratification the progress that some countries of our Region have achieved in their efforts to return to breastfeeding and to re-establish it as the norm. The Islamic Republic of Iran provides one such example. Over a period of just a few years, it has been able to reduce imports of breast milk substitutes to less than one tenth of its previous figure. This is a clear indicator of a marked return to breastfeeding, because the great majority of breast-milk substitutes used in our Region are imported.

One important aspect of child care which meets health requirements, and fits in with essential cultural values in our Region, is immunization. To neglect immunization is to expose young children to risks of disease that threaten their lives or expose them to illness and disability. That means leaving them to perish, and according to our values, that is

sinful. As the Prophet Muhammad ﷺ said: "It is sufficient of a sin for any person to allow his dependants to perish."

In point of fact, people's response to immunization programmes in our Region has always been naturally positive. This is mainly due to the well established family values. However, it remains the responsibility of the health authorities to ensure that immunization programmes have all the resources needed to achieve their clear objectives. The first of these objectives is to maintain high rates of coverage and to improve these rates year after year. Routine immunization is the cornerstone in our strategy to reduce the incidence of targeted diseases, and eventually to eliminate and eradicate them.

It is essential to strengthen our surveillance systems for target diseases, particularly those for poliomyelitis and acute flaccid paralysis. We cannot make certain of the elimination and eradication of poliomyelitis unless we put in place strong and effective surveillance systems, whose results confirm the disappearance of the disease. Unfortunately, surveillance systems are still weak in a number of Member States in the Eastern Mediterranean Region. In addition, the private sector, which provides a major portion of the medical services in many countries, remains unconcerned with the surveillance systems. This state of affairs must be changed. Without strong surveillance systems, we cannot be sure of what has been already achieved and the task that remains ahead. And without full cooperation on the part of the private sector with the surveillance systems, our work remains incomplete and its results unconfirmed.

All countries of the world have made great efforts towards the achievement of the complete eradication of poliomyelitis. These efforts will remain a source of pride for all humanity for many generations to come. Yet greatly important as it is, what has been achieved requires further efforts to bring it to completeness and fruition. We must not stop our work or consider that our goal has been achieved until the last remaining pockets where the disease persists have been completely purged and the disease is certainly and finally eradicated from every area throughout the whole world. Some countries have contemplated the cessation of national immunization days, because there have been no new cases of poliomyelitis within their territories for over three years. However, such a step may open the door for the importation of the wild poliovirus from countries where it remains in circulation. That will bring back the disease and ruin what has been achieved. This must not be allowed to happen anywhere, regardless of the circumstances.

May I give an analogy of the present situation with regard to poliomyelitis eradication? We are just like an athlete taking part in a long race. That athlete has already completed most of the distance and is approaching the finishing line, feeling that his energy is still at a high level. Is it conceivable that such an athlete should stop only because he knows that he has no problem completing the race? All that is left to reach the deadline of poliomyelitis eradication is a little over 800 days. It is imperative to continue our efforts to achieve the goal we have set for ourselves, or in other words, to reach the finishing line and claim the winning medal. It is wrong for anyone to slacken now. On the contrary, we must

continue our efforts until we are sure that poliomyelitis has gone the way of smallpox, and will never return.

The epidemic which I consider more difficult to eliminate than both poliomyelitis and measles together is one which presents an unparalleled list of health risks: smoking. It is the only epidemic that is actively promoted by certain interests. There are no organizations that promote tuberculosis or malaria, and no multinational companies that sell AIDS or mental ill-health. But we have powerful commercial concerns, both national and international, spending billions of dollars every year to sell tobacco, with all that it causes: a great range of cancers, cardiovascular diseases and other types of illness.

We cannot adequately describe the health hazards caused by smoking, no matter how hard we try. The truth remains far worse than our words can imply. Therefore, I will confine myself to highlighting some simple facts. In our world today, one person dies every nine seconds from a tobacco-related disease. Unless we all join ranks in a determined effort to reverse this tragic situation, it will deteriorate even further and in less than 25 years time there will be one death every three seconds from a tobacco-related disease.

It is heart-breaking to witness how the young boys and girls in this Region are seduced into taking up this evil habit. Having lost a large chunk of their markets in developed countries, the multinational tobacco companies have turned their attention to the developing countries. They try to circumvent the laws and regulations in countries where tobacco promotion is illegal in order to promote their foul product by all manner of devious means, including advertising on satellite channels, foreign radio stations and the print media published outside national borders. Another method of promotion is the new fashion of the water pipe, or *narjeelah* or *shisha*, which is becoming so common among both men and women in some countries of the Region in cafes and restaurants, and indeed in what is called the Ramadan tent. Needless to say, such promotion constitutes a clear desecration of the spirit of the fasting month of Ramadan.

Two years ago, the Regional Committee approved a plan of action for tobacco control in the Eastern Mediterranean Region. This plan of action aims to combat the fearful rising trend of tobacco imported and consumed in this Region. A number of countries have taken the lead, promulgating laws and regulations, and forming national councils or committees for tobacco control. But we still have a long way to go. The efforts required are far greater than what we are actually doing. It is important that countries of the Region work in unison to make their efforts in this regard complementary. They should concentrate their efforts on increasing everyone's awareness, but particularly that of the younger generations, that smoking is harmful to health, socially unacceptable and forbidden in religion. This is a prerequisite for reducing the consumption of tobacco, prior to its ultimate elimination. At this juncture, I would like to commend the proposal of the Mufti of Egypt that each packet of cigarettes sold in the Region should carry in addition to the health warning a religious warning saying: "Smoking is forbidden by religion." This will bring religious influence, which is strong in our Region, to bear upon our cause.

Social solidarity is one of the distinctive characteristics of communities in this Region. It is firmly rooted in people's minds. Its practical effects are clearly apparent in local, rural and urban communities. Extending a helping hand to a needy person, or one in straightened circumstances, giving priority to helping others, removing hardships that deprive vulnerable people of the chance to lead a decent life, and empowering people to do by themselves that which will benefit their families and communities are all part and parcel of the cultural concepts and values of this Region. Perhaps this is the underlying reason for the spectacular success of the Basic Development Needs initiative in countries of the Region. This initiative relies on two essential concepts. The first makes it clear that health development can only be realized within a broader framework of comprehensive economic and social development. The second holds that even in the most deprived and weakest of situations, the local community is the one best suited to determine its most essential needs for development and to determine their priority. It is also the best able to meet these needs provided that it has the necessary mechanism and the basic material resources to start the development process.

The practical application of the Basic Development Needs initiative in 13 Member States has proved beyond any doubt that the response of the local communities in poor and deprived areas is both positive and natural. They find in it an approach that is akin to their ideals, dealing directly with their situations, and making use of their own potential, which is rarely turned to advantage by the traditional methods. Needless to say, every community, however deep in poverty and deprivation it may be, has values and resources which enable it to make a valuable contribution and to shoulder responsibility. When we try hard enough to tap these resources, the results are often far more spectacular than expected.

I am particularly gratified that the Government of Pakistan has approved the Basic Development Needs initiative as a national strategy for poverty alleviation. It has allocated in its federal budget more than four hundred million dollars for the implementation of this strategy throughout Pakistan over the next five years. This judicious decision provides an example to follow in other countries. It is well known that poverty is widespread in our Region, but it is also a fact that it can be overcome when we work together to tap the resources of the local community and the potential and talents of its individuals. Furthermore, our experience in this field is exemplary in its success. As the Director-General has placed poverty alleviation at the top of her priority list, I would like to place our experience in this respect at her disposal.

Countries of the Region are facing the immense challenges set by what is now known as the new world order. Our challenge may be seen in how the health sector responds to the successive global changes in various areas. Foremost among these changes is the powerful trend towards globalization, with all that that entails in terms of freedom of trade, including in the area of health services, on a worldwide basis, and the great revolution in information technology. It is expected that these developments will lead to a fundamental change in the health sector. It is also expected that this will be coupled with negative effects on the health systems in developing countries, and a fundamental reassessment of the roles of the State and the private sector in providing such services. Given this situation, I feel it to be my duty

to call on the leadership of the health sector, particularly Ministries of Health to try to bring about a situation which accomplishes the reform of the health sector within the framework of a national health policy that sets well-defined national goals to meet the essential health needs of the whole population.

May I conclude my address by expressing our sincere thanks and gratitude to the Lebanese Government for hosting this session of the Regional Committee. I particularly commend the efforts it has made and the excellent facilities it has provided to ensure the success of this session. I am particularly thankful to His Excellency Mr Sleiman Frangieh, the Minister of Public Health, and his assistants for the hospitable welcome extended to us on arrival. I pray to God to bless our efforts and give us sincerity of purpose in our work so that it may bring benefit to all peoples of this Region. May God bless you all.

Annex 4

**ADDRESS BY DR GRO HARLEM BRUNDTLAND, WHO DIRECTOR-GENERAL
to the
FORTY-FIFTH SESSION OF THE REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN**

Beirut, Lebanon, 3–6 October 1998

It is a message of hope and inspiration to us all that the Regional Committee for the Eastern Mediterranean is meeting here today in Beirut. I am delighted to be in Lebanon to speak to this distinguished group of health leaders.

I hope to be able to share with you my vision of the future for WHO and world health and to listen and learn from your own ideas and concerns.

When WHO was created, only six nations of the Eastern Mediterranean were able to lay the foundations. Now there are 22 countries of the Region able to celebrate our 50th Anniversary year. We can look back at impressive achievements: yet we enter a new century where no one could claim that our agenda was fulfilled. There is still so much to do. Our task is clear: to see to it that an effective WHO will be there to pave the way towards better health in all its Member States.

This is the sixth and last Regional Committee that I will have attended since the beginning of September. Harare, New Delhi, Manila, Copenhagen, Washington and now Beirut—they all represent an extraordinary opportunity to tap the experiences of health officials around the world.

To me this is key: WHO is complete—our identity intact, our course on target—only if we include the regional dimensions—if we add them up. I see this as a main challenge: to make WHO one, not seven organizations—Geneva and the six Regional Offices.

Let me take this opportunity to share with you a few issues which I believe are important for our organization and for the Region, and to share with you the process of change that I have initiated with my colleagues in the WHO Secretariat.

We need to broaden our perspectives

My first observation relates to the advantages of having a broad perspective on health. Important determinants of better health lie outside the health system. They include better education. A cleaner and safer environment. Sustained reductions in poverty. A stop to armed conflict and excessive military expenditures. We simply cannot appreciate or fully address the health challenges by only focusing on the health sector.

Right now there are many peoples in the Region who are faced with armed conflict. Infrastructure in a number of countries has been and continues to be destroyed, health centres are devastated and thousands and thousands of people are left with mental and physical scars.

We need to add our efforts to the prevention of conflict. And we can make a difference. For example a great service can be done to the health of this Region and the rest of the world by more countries ratifying the treaty to ban anti-personnel landmines which came into force last month with 40 ratifications. I ask you to join with Djibouti and Yemen from your Region which were among those countries.

What can WHO do? We have to emphasize the message to the international community: peace is an absolute need for sustainable health and human development. And WHO has to aid the victims of conflict—support proper health services for refugees, emergency care, rehabilitation for those wounded or disabled.

Health workers are on the receiving end not only of the impact of war and conflict but of many of society's other problems and inequities. They are often left with dealing with the outcome of events. At the same time we know that making right and timely investments in health benefits society at large.

We have the evidence: investing in health gives tangible results. Less social and economic costs. More human progress. Enhanced capacity for society to harness the human resources that will be at the forefront of development in the 21st century.

You, the Health Ministers, already know. Together we need to go beyond and tell the Presidents, the Prime Ministers and the Finance Ministers that they are really Health Ministers themselves.

I believe we can succeed in putting health at the centre of the development agenda. Not alone. But by gathering our evidence, by matching it with that of others, by becoming better advocates, and by reaching decision-makers with a convincing case. This requires new momentum and new methods of work.

We need to reach out

My second observation concerns the advantages of our reaching out—to other UN Agencies, to other key players in health, and to civil society. The very notion of a specialized agency makes little sense in this interdependent world. The projects and workplans of WHO will put specific emphasis on these partnerships. WHO can be a stronger lead agency in health by entering into partnerships of stakeholders.

WHO should focus on problems that cross boundaries, on generating and disseminating a global evidence base, on promoting research that goes beyond corporate or national agendas. That is how we can really be efficient and make a difference at a country

level—in our technical work—and in our setting of norms and standards. That is how WHO will provide the intellectual and moral leadership required to ensure Health for All.

These themes of partnership and focus apply to our work in the Eastern Mediterranean Region. We need to maintain close contacts with the regional structures of our United Nations partners and with other regional institutions including those in the economic fields.

This will enable us to tackle a key issue that I know is of concern in the Region, namely to develop better strategies for linking health and trade issues. These include conventional areas of concern, such as harmonization of occupational and environmental health standards. They also involve balancing our mandate to protect the health of people from potential hazards with the imperative to avoid using health regulations as trade barriers. And they include new areas that are increasingly becoming crucial as globalization advances, such as the trade in health-related services and products.

We must also reach out to the private sector. I have said that WHO will engage the private sector in constructive dialogue and this will be of critical importance with regard to the pharmaceutical sector. National and international drug policies should help extend access to essential drugs of good quality, safety, and efficacy. This requires strong national regulatory authority and intelligent government purchasing policies.

Your technical discussion this year on the regional initiative for self-reliance in the production of essential drugs and vaccines is very timely. Upgrading national capacities not only in production but also in the quality assurance of locally-manufactured drugs and vaccines is an important priority.

We are looking for the right balance. National strategies must ensure equity of access, rational use, and assured quality for existing drugs. Issues of drug financing and affordability are critical. At the same time, to meet pressing public health needs we need new drugs and vaccines. This is true for emerging diseases, but also true because of the serious threat from growing resistance to drugs for common killers such as tuberculosis, bacterial meningitis, and pneumonia. To develop new drugs we need innovative industry research, with appropriate incentives for innovation and protection of intellectual property rights.

International organizations and governments should address pharmaceuticals issues within their areas of competence and responsibility, in order for these important issues to be handled in a satisfactory and timely manner.

It is time for an increased and ongoing dialogue between WHO and the World Trade Organization. I have scheduled a meeting with Director-General Ruggiero to discuss how we can work together on ways to further both international commerce and international commitments to health.

We need to cope with the shifting burden of disease

My third observation concerns the shift in the global burden of disease from communicable to noncommunicable diseases. Countries in your Region are experiencing this. And scores of developing countries worldwide are moving in the same direction, posing an exceedingly hard challenge to their health systems.

The double burden of communicable and noncommunicable disease problems is already upon us. Many countries are suffering still with common infections and reproductive health problems. Without having fully solved these challenges, they are already facing the emerging problems represented by noncommunicable diseases and new infections.

Contrary to common misconceptions, inequalities do not follow a simple dividing line whereby communicable diseases would be mostly the problem of the poor and noncommunicable ailments would affect the rest of the population. The brutal fact is that the poor suffer higher rates of both types of diseases.

Let me make some references to health challenges of the Region

The importance of markedly accelerating **polio activities** in the Region cannot be overstated. Although dramatic progress has been achieved in the most difficult areas of Afghanistan, Pakistan, Somalia, Yemen, Sudan and northern Iraq, much remains to be done.

The force of the worldwide initiative for elimination must be maintained. In 2010 we should be able to look back at the year 2000 and say that we reached the goal of eradicating polio. But we may also fail. We are now learning that the eradication campaign may be running critically short of funding.

That is not acceptable. This is a combat we simply cannot afford to lose on the last stretch. It is estimated that 600 million dollars will be needed till the end of 2000. Donors have to go the extra mile with us and rid the world of polio and its tragic toll on death and disability. All countries have to make a reinforced effort led from the very top.

I have pledged WHO's determination to lead in a renewed international effort to **Roll Back Malaria**. I am pleased that one of your technical papers this year presents an analysis of the current situation. In some countries of the Region, eradication was possible but in others we have seen a resurgence. In the most heavily affected countries we need to attack the disease by focusing on strengthened health systems. The project staff is currently preparing the work in close dialogue with the Regional Offices and gradually with the countries concerned. I urge you to join us.

More than 90 per cent of the **tuberculosis** in the Region is concentrated in eight countries, of which Pakistan, Afghanistan and Sudan have the major burden. The efforts

made by the Regional Office and Member States since your regional resolution last year have been commendable. But we will continue to see the incidence and mortality of tuberculosis in the Region expand over the next ten years unless we make a major effort. WHO will demonstrate leadership—by placing our TB efforts in a broader context, by focusing on the health sector and by working more closely with other partners.

Countries, and WHO, have no choice but to address the double burden of communicable and noncommunicable diseases simultaneously. We now know more about how to manage cases of noncommunicable diseases. We need to do more work on the initiatives that have already begun in some countries of the Region for community-based intervention programmes for primary care of noncommunicable diseases. We need to see if we can develop a regional network in this regard.

As we continue to improve case management, we must seriously focus on controlling risk factors. And let there be no secret: **tobacco** is by far the most important.

Tobacco is already an importance cause of death in the Eastern Mediterranean Region. Thirty-five per cent of the male population smoked in the Region in 1990. It is estimated that the burden of disease attributable to tobacco use in the Region amounted to more than 100 000 deaths and more than one million years of life lost in the early 1990s.

You are acting—and I lend you my full support. The day I took office, I launched the Tobacco Free Initiative, a Cabinet project to add momentum to this critical public health struggle.

I told the World Health Assembly back in May: I am a doctor. I believe in science and evidence. Let me state it clearly: tobacco is a killer. It should not be advertised, subsidized or glamorized. Adolescents should not be allowed to mortgage their lives to the seductive advertisements of the industry.

WHO's Tobacco Free Initiative aims at galvanizing global support for tobacco control. We need to ensure that our policy is backed by people, money and institutions, not just in Geneva, but also in the Regions and within all Member States. We need to reach in and reach out to build "partnerships with a purpose" for combating this epidemic.

Because of the importance of cessation, I have designated World No-Tobacco Day 1999 to focus on this problem. This should create opportunities for health professionals, governments, NGOs, media and pharmaceutical companies to work together towards a common goal.

Through your EMR 1995 Action Plan on Tobacco or Health, you are providing leadership and inspiration at the regional level in the fight against tobacco. Some countries in your Region have already banned tobacco promotion, created smoke-free areas in public places, and have raised tobacco taxes which discourages youth smoking.

We need to cope with health sector reform and development

How can we build sustainable health systems that can stand the test of changing times and economic constraints? How can we ensure access to basic health services in situations where the base of public finance is under pressure?

Each country must choose its own path—based on its pattern of disease, its institutions, its resources, and the needs of its people. But WHO must always be there, ready and able to assist you, and to share with you the experiences gathered through different models applied in various countries.

Recent years have witnessed the emergence of a world-wide movement for health system reform. Half a century after most current arrangements for organizing health care were set in place, we are again living through a period of innovation. Most countries seek to find better ways of facing the complex health challenges of our times.

What goals should guide health sector reform? By what criteria should we judge success or failure?

I see three concrete goals:

- Measurable reduction in the huge inequities that still plague us—inequities both within and across countries;
- Sustained, measurable reduction in the burden of disease;
- Universal access to efficient health services that respect the needs and dignity of each individual.

A key responsibility for Governments should be to secure access to care. Only the public sector can guarantee basic universal rights. That is a useful reminder in this year of the 50th Anniversary of the Declaration of Human Rights as well as of our own Constitution.

The performance of market forces has enormously increased productivity in many sectors of the world economy. The health sector is also benefiting. But just as the private for-profit sector may be good at allocating resources cost-effectively, it is seldom the key provider of primary health care or the guarantor of securing health services to the poor. Neither will it assure universal access.

We need to start a discussion on norms and standards of a “**new universalism**”—a new way of addressing universal coverage. This will be a major issue on the agenda of each country. Accordingly it has to be a WHO priority, and we are organizing part of our work to deal with it effectively. Everything we do should contribute to health sector development.

Universal access to quality services is a bedrock principle. Governments should provide strategic leadership—through setting priorities—accepting that there are limits to the care Governments can finance, limits that each country must decide for itself. But setting priorities and defining limits require knowledge of which efforts will make the best impact, reach the most people, and achieve the most effective results.

WHO should be there to advise you in this process. The new universalism embraces all potential contributors to better health—public sector, private sector or NGOs. Provision of government financed service must come from the most efficient source, not necessarily from public sector providers.

In order to make health system reform a sustainable process, we must engage in a process of shared learning. Every reform experience contains valuable lessons for other countries. Systematic information on such experiences is an international public good. An essential function of institutions like WHO is to mobilize international collective action to ensure that such public goods are effectively produced and disseminated.

In everything we do there is a growing need to underpin our work with solid facts. We must have the right figures and the best evidence—not only the moral conviction that health is essential. We have created a special Cluster called Evidence and Information for Policy. This knowledge base is there for you to use. And to enrich. We will report important facts. And the fact is that healthy people help build healthy economies.

Let me end by sharing with you some key elements of the WHO reform process

On 21 July I took office and appointed a new senior management team at headquarters level. We are five members from the South and five from the North. Six women and four men. All WHO's Regions are represented in a strong global team.

Together with the Regional Directors, the WHO Representatives and more than 3500 staff we are embarking on a process of change along the lines I presented to the World Health Assembly in May.

We must secure a better unity of purpose of what we do. We should be very good at what we decide to do—and ready to say that we cannot do all.

We need to be able to say that WHO is one: setting its priorities as one, raising additional resources as one, speaking out as one. Let us not forget: WHO is a small organization if we measure it against its mandate—and against the scores of unmet needs. WHO is not a deliverer of health services: national and regional authorities are. NGOs, private providers and communities are. You are. It is through our combined efforts that we can make a difference.

Changes are nevertheless being made in our budgets. At the World Health Assembly, Member States decided after long discussions to change the regional allocations and to increase resources from the regular budget going to the African and European Regions.

I know this has faced the other Regions with some difficult decisions, especially at times of financial and economic problems. I know that there are particular concerns in this Region that Dr Gezairy has personally written to me about and we have discussed them. I shall do everything I can, looking beyond the regular budget, to mobilize funds to support our activities, especially towards the countries in greatest need.

At headquarters, we have now grouped the programmes into nine Clusters—each sending a clear message of what business we are in. In the coming months, under the supervision of the Executive Directors, each Cluster will streamline its activities in order to optimize what we can do together—across the Organization and in partnership with others.

We continue to focus on communicable diseases and noncommunicable diseases. And we are moving to address the challenges of a changing world. The Cluster on Social Change and Mental Health will try to capture the health challenges from changing and aging societies, with a particular focus on the unmet needs within the field of mental health. The Cluster on Sustainable Development and Health Environment will strive to make the link between a globalized world and the strains on people's health from poverty and a growing burden on our environment.

In everything we do we have to remind ourselves: What we do in Geneva or in Alexandria matters very little if it does not have an impact in the countries in terms of better WHO collaboration, better pooling of knowledge, better global advocacy for health and better resource mobilization.

Not long ago, I met with the Regional Directors for a first discussion of our common work. I see the Regional Directors as an integral part of the senior management team of the Organization and I intend to establish and maintain a closer contact with them. We have started a major modernization of our information technology network which will enable us to link the six corners of the world by the push of a button, by voice or by image in real time. There will be better communication and there will be money saved from doing away with unnecessary travel.

I will establish more direct relations with the WHO country representatives and in a few months, I will invite country representatives to Geneva to learn from their experience and to introduce them to the new WHO and what it has to offer—in order to strengthen the bridges to the Member States—and in particular those in greatest need.

I will invite the Executive Board to closer contact and more focused debates on the challenges facing us. Two weeks from now, I will meet the Board at an informal retreat to introduce the change process and share ideas on the strategic way ahead.

I will establish closer relations with the private sector by inviting industry to roundtable discussions and exchange—to explore what we can do in common and where our views and interests differ. And I will meet more regularly with the NGOs and define new opportunities of working together.

You know it from the numerous calls from the Governing Bodies: Member States want more relevant and tangible results from our efforts at the country level. The time has come for the Secretariat to make its response. We have initiated a fast-track task force to make concrete recommendations on how we can turn the ambitions into reality.

Gradually you will see that we are changing the way we work. More of our work will be organized in projects that cut across Clusters and Regions and that frequently engage other partners. High visibility, intensive efforts, tangible targets. We have launched two such projects since 21 July—Roll Back Malaria and the Tobacco Free Initiative, which I referred to earlier.

The bottom line is this: we need to make WHO more user-friendly, more evidence-based—for you, the Member States, who need it most, so that you can get more out of your health policies. This is a process of hope. We can do better. We will do better.

Mr President, Ministers, Colleagues, Ladies and Gentlemen

Yes, there are scores of unmet needs. But the health sector has a track record of success over the past half century; it is our mandate, yours and mine, to carry that record forward. Progress in the next century will depend on our ability to explore the potential of the human resource. We go nowhere unless we succeed in building healthy populations in healthy communities.

Science has given us powerful tools. The need now is for political, financial and ethical commitment. Commitment and responsible use of science can aid us in our search for ever better ways to prevent and treat the constantly evolving disease challenges we face.

Your Region has a long history of cooperation for health. We can look back with legitimate satisfaction to our accomplishments. But we must also look forward to the challenges that are already with us, many of which derive from the very progress that we achieved during the 20th century.

Others are the result of the agenda that we have not been able to fulfil. Still others will emerge as unprecedented problems of the future, and we must be prepared today in order to anticipate them.

These challenges are a call for action—evidence-based and value-driven. Together we can make a difference for health—today and in the times to come.

Annex 5**FINAL LIST OF DOCUMENTS, RESOLUTIONS AND DECISIONS****1. Regional Committee documents**

EM/RC45/1 Rev.1	Agenda
EM/RC45/2	The work of the World Health Organization in the Eastern Mediterranean Region—annual report of the Regional Director for the year 1997
EM/RC45/3	Proposed Programme Budget for the Eastern Mediterranean for the Financial Period 2000–2001
EM/RC45/4	Resolutions and decisions of regional interest adopted by the Fifty-first World Health Assembly and by the Executive Board at its 101st and 102nd sessions
EM/RC45/4(a)	Regional allocations
EM/RC45/4(b)	Other resolutions
EM/RC45/4(c)	Nominations of representatives from the Eastern Mediterranean to the subgroup of the Ad Hoc Working Group on the Revised Drug Strategy
EM/RC45/4(d)	Review of the draft provisional agendas of EB103 and WHA52
EM/RC45/5	Report of the Regional Consultative Committee (twenty-second meeting)
EM/RC45/6	The role of private and nongovernmental sectors in the national health care delivery system in Lebanon: reform proposals (special presentation)
EM/RC45/7	Evaluation report of the Joint Government/WHO Programme Review Missions in 1997
EM/RC45/8	Healthy villages programme (special presentation)
EM/RC45/12	Acquired immunodeficiency syndrome (AIDS) in the Eastern Mediterranean Region
EM/RC45/13	Development in nursing and midwifery
EM/RC45/14	Draft regional health-for-all policy and strategy for the 21st century

EM/RC45/17 Subjects for technical discussions and technical papers in 1999 and 2000

EM/RC45/18 Down syndrome—establishment of a regional research prize foundation

EM/RC45/19 Revision of the International Health Regulations

EM/RC45/Inf.Doc. 1 Award of Dr A.T. Shousha Foundation Prize

Technical discussions

EM/RC45/Tech.Disc. 1 Regional self-sufficiency in vaccine and drug production

Technical papers

EM/RC45/9 Technical paper: emerging and resurging diseases in the EMR with special reference to malaria

EM/RC45/10 Technical paper: cardiovascular disease prevention and control

EM/RC45/11 Technical paper: GATT Agreement—its impact on health

Nominations

EM/RC45/15 Nomination of a Member State to the Management Advisory Committee (MAC) of the Action Programme on Essential Drugs

EM/RC45/16 Nomination of a Member State to the Joint Coordinating Board on the Special Programme for Research and Training in Tropical Diseases

EM/RC45/Inf.Doc. 2 Place and date of the next Session of the Regional Committee

2. Resolutions

EM/RC45/R.1 Annual report of the Regional Director

EM/RC45/R.2 Proposed programme budget for the Eastern Mediterranean Region for the financial period 2000–2001

EM/RC45/R.3 Emerging and resurging diseases in the Eastern Mediterranean Region with special reference to malaria

EM/RC45/R.4	Draft regional health-for-all policy and strategy for the 21st century
EM/RC45/R.5	Regional self-reliance in the production of essential drugs and vaccines
EM/RC45/R.6	Acquired immunodeficiency syndrome (AIDS) in the Eastern Mediterranean Region
EM/RC45/R.7	Prevention and control of cardiovascular diseases
EM/RC45/R.8	The Regional Consultative Committee (twenty-second meeting)
EM/RC45/R.9	Down syndrome—establishment of a regional research prize foundation
EM/RC45/R.10	GATT Agreement—its impact on health
EM/RC45/R.11	Evaluation report of the joint Government/ WHO programme review missions in 1997
EM/RC45/R.12	Improving the quality of nursing and midwifery in the Eastern Mediterranean Region
EM/RC45/R.13	Place and date of the next Session of the Regional Committee

3. Decisions

Decision 1	Election of officers
Decision 2	Adoption of the agenda
Decision 3	Nominations of representatives from the Eastern Mediterranean to the Subgroup of the Ad Hoc Working Group on the Revised Drug Strategy
Decision 4	Nomination of a Member State to the Joint Coordinating Board on the Special Programme for Research and Training in Tropical Diseases
Decision 5	Nomination of a Member State to the Management Advisory Committee (MAC) of the Action Programme on Essential Drugs
Decision 6	Closing session