

# Health developments in the Eastern Mediterranean Region over 50 years

*Excerpts from the records*

## Introduction

The world health situation immediately after the Second World War was next to chaos. One of the earliest decisions taken by the Allies was to establish the World Health Organization (WHO) as an integral part of the United Nations system, which was being developed as a new international order based on the principles of peace, equity and human rights.

The World Health Organization was formally established on 7 April 1948. Following its constitutional requirements, six geographical areas were established with homogenous socioeconomic situations and similar health problems. The Eastern Mediterranean Region was one of these six areas. It was delineated by the First World Health Assembly in July 1948 and comprised the following countries and territories: Aden, British Somaliland, Cyprus, Dodecanese Islands, Egypt, Eritrea, Ethiopia, French Somaliland, Greece, Iran, Iraq, Lebanon, Pakistan, Palestine, Transjordan, Tripolitania, Turkey, Saudi Arabia, Syria and Yemen.

The Regional Office for the Eastern Mediterranean, acting as the executive arm for the Eastern Mediterranean Region, started to function on 1 July 1949.

Over the years, many changes have taken place in the composition of the Region, as a result of political changes, such as independence of some countries, unification of others and transfers between the Eastern Mediterranean and other regions. The

present composition of the Eastern Mediterranean Region is: Afghanistan, Bahrain, Cyprus, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen. The Palestinian National Authority has the status of observer in the Regional Organization.

The world health situation has changed fundamentally during the 50 years the WHO has been in existence. The Eastern Mediterranean Region is no exception. The regional health profile in the nineties is indeed different from that of the forties. This change is the result of a relentless, uninterrupted, purposeful effort made jointly by WHO and the Region's Member States. These developments were carefully documented in *EMRO, Partner in health in the Eastern Mediterranean, 1949-1989*, from which much of the following information is extracted. The book was edited by Alexander Manuila and published in 1991 by the WHO Regional Office for the Eastern Mediterranean.

## The first three sessions of the Regional Committee

The first WHO Eastern Mediterranean Regional Conference took place in Cairo in 1949. This was in effect, the first session of the WHO Regional Committee for the Eastern Mediterranean. Delegates at the Cairo

conference successively reviewed the health situation in the countries or territories they represented, indicated the preventive and curative measures they were already taking and specified the type of medical aid they would like to receive from the fledging WHO.

It became clear that because of climatic conditions, the impoverished state of much of the population and a lack of medical equipment and trained personnel, health in the Region was very poor. Among the common diseases were schistosomiasis, malaria, tuberculosis, sexually transmitted diseases, relapsing fever, trachoma and typhoid fever. The influx of refugees into countries bordering on Palestine and into Pakistan, following political and military developments, was causing special problems of great urgency. Also, in some countries, notably Iraq and Syria, drug abuse was a growing health concern.

The delegates reported that they needed not only drugs such as penicillin and streptomycin, but also the help of medical experts and qualified advisers, and fellowships so that health personnel from their countries might study abroad. Dr Brock Chisholm, WHO Director-General, informed them that the Organization's limited budget would permit the supplying of only very small amounts of medical supplies in 1949 and 1950, but that, within the limits set by available funds, steps would be taken to provide expert help and advice and fellowships for medical studies. For Eastern Mediterranean Regional Office (EMRO) operations in its first six months, the conference participants recommended a budget of US\$ 112 000, to cover administrative expenses and the cost of epidemiological notifications. This was a very small amount with which to start a health programme, but it was anticipated that it would grow in future years.

The Second Session of the Regional Committee for the Eastern Mediterranean was held in Geneva in October 1949.

The delegates evolved a programme that aimed to coordinate and reinforce the efforts of the various countries by applying recommendations made by the Second World Health Assembly and by efficient functioning of national health administrations. The Committee recommended that Member States increase their allocations for public health and provide for the application of specific measures wherever they were not yet in force, such as compulsory vaccination against smallpox, or the creation of special organizations for maternal and child health care. The tasks of governments were to be facilitated by expert consultants, attached to the Regional Office, in matters relating to public health administrations, sanitation, nursing and health education.

The Regional Director asked delegates to suggest ways in which they might help other countries in the Region. These proposals and a unanimous decision to promote the exchange of health personnel among the Region's Member States reflected the spirit of collaboration and mutual aid that prevailed through the discussions.

The Regional Director, in his opening address to the Third Session of the Regional Committee, on 4 September 1950, observed that the first year had been devoted very largely to perhaps somewhat unspectacular but nevertheless essential spadework. Although the Regional Director was able to report on activities that were under way in several countries (e.g. malaria-control teams in Iran and Pakistan, a tuberculosis centre in Istanbul, consultative services to nearly all countries, fellowships for training and ongoing epidemiological services), the main priority remained collecting data on major health problems in the Region. EMRO had sent 214 separate requests for information

to Member States and with only one or two exceptions, the response had been satisfactory.

This gave Dr Shousha and EMRO an opportunity to assess the magnitude and complexity of health problems in the Region and to begin to make plans to help public health administrations overcome them. Consultants and advisers, experts in subjects such as malaria, tuberculosis, sexually transmitted disease, maternal and child health, environmental sanitation and public health administration, had visited many countries in the Region, making surveys, consulting with local health authorities, and submitting reports intended to aid in drawing up plans for action.

Despite the dissimilarities among countries, certain general conclusions had already emerged that superficially seemed to have much in common. The better the economic, social and cultural conditions of a country, the better was the health of its people. Some of the diseases that were most widespread in the Region were due, in large measure, to lack of environmental control. In general, urban populations were benefiting more than rural populations from the existing public health services, that curative medicine was far more highly developed than preventive medicine, and that medical care, which embraced both, was sadly inadequate for the actual needs of the Region, public health services in most countries being still in an early stage of development. The information received at EMRO made it all too clear that health care and its development were hampered chiefly by lack of funds and a chronic shortage of trained health workers, and that rural areas were especially badly served because of widespread of maldistribution of the facilities that did exist.

Dr Shousha emphasized the urgent need to combat endemic diseases, which were afflicting large sections of the population of

many countries. In this struggle, WHO was expected to be particularly helpful through demonstrations that, apart from their immediate beneficial effects, might serve to mobilize public opinion in favour of their expansion and general application as the results became known and appreciated. However, the Regional Director pointed out that international health, however valuable as a stimulant, could not replace the necessary initiative of the governments themselves in developing campaigns to overcome the health problem of their countries.

Dr Shousha said that the contrast between expenditure on defence and expenditure on health was becoming much more acute in most parts of the world. He reminded the delegates of their obligations laid down in the Constitution of the World Health Organization, to keep on pointing out to governments that the enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition and, finally, that, as expressly stated in the Constitution and ratified by all Member States, governments had a responsibility for the health of their people which could be fulfilled only by the provision of adequate health and social measures.

Among the decisions taken by the Regional Committee at its Third Session, the following deserve mention, to give the reader some idea of how business was handled at the regional level in the early days and of the atmosphere that prevailed during the meetings. Specifically, the Regional Committee:

- urged Member States to make adequate provisions in their national budgets for public health services and for the training of necessary personnel;
- expressed the opinion that short-term consultants should be appointed only for special purposes, and that Regional Ad-

visers should spend sufficient time in the countries they served to enable them to accomplish their tasks satisfactorily;

- recommended that Regional Advisers on environmental sanitation and on malaria be appointed; that the BCG vaccination campaign be continued and that rehabilitation of tuberculosis patients be considered an integral part of a comprehensive tuberculosis campaign; that an intraregional training programme for control of sexually transmitted diseases be undertaken; and that countries in the Region be encouraged to develop research on treponematoses;
- noted provisions made for activities relative to typhus and relapsing fever, schistosomiasis, cholera, rabies, leprosy, nutrition, maternal and child health, and mental health;
- requested the Regional Director to explore the possibility of convening a regional seminar on trachoma and to develop an intraregional and interregional fellowship scheme for training personnel to deal with trachoma; to stimulate research on the epidemiology of leishmaniasis and include complementary programmes for leishmaniasis control in those of malaria demonstration teams operating in areas where the former disease was prevalent;
- called upon Member States to develop an effective school health service and health programme for school-age children; to improve their smallpox vaccination services where necessary; to give attention to pertussis, making its notification compulsory and developing treatment with antibiotics; requested further study on the value of mass vaccination against pertussis;
- authorized the Regional Director to act on its behalf in matters pertaining to the

United Nations Technical Assistance Programme and urged the countries of the Region to cooperate closely with the Regional Office concerning requests and projects relating to the health aspects of the programme.

### Health conditions in 1953

While the upper classes had much the same birth-rate, life expectancy, standards of housing and education as their counterparts in Western countries more than three-quarters of the people of the Region in 1953 lived very much as they did many centuries ago. The professional middle class, which plays such a large part in the affairs of Western countries, was comparatively undeveloped in the Region. By and large, statistical data for the Region were inadequate and usually not very reliable. Egypt, which was in many ways one of the best-developed countries, had a census taken at 10-yearly intervals that was fairly reliable; but this could be said of practically no other country in the Region.

The main achievement of modern public health methods had been the control of pestilential diseases. When these diseases appeared in epidemic form they were localized and stamped out by national health services, with assistance, if necessary, from outside.

The fight against debilitating endemic diseases had begun. The most important successes being in combating malaria, which had been almost entirely eliminated from Cyprus, confined to small areas in Israel and Lebanon, and brought under control in some districts of other countries. The village populations in most areas, however, were still burdened by a combination of such chronic illnesses as malaria, trachoma, schistosomiasis, hookworm and sexually transmitted diseases. Most governments were planning to launch campaigns against these diseases, through use of insecticides, drainage of

swamps and canals, provision of adequate waste-disposal systems and hygienic water supplies, and establishment of village clinics and dispensaries. In the majority of the countries concerned, such measures existed in only a small proportion of the population.

There was a basic and urgent need not only to train many more doctors, nurses and public-health officers, but also to develop a medical and health corps dedicated to rural services. The financial difficulties involved in developing such trained personnel, and in supporting their work among poverty-stricken villagers who could not afford fees, constituted a tremendous problem as did the difficulties that arose from the fact that city-trained medical and health personnel were often reluctant to live and work in isolated villages where they enjoyed few of the amenities and satisfactions of urban life.

The nutritional level of many people was unsatisfactory. Diet often consisted mostly of cereals, pulses and vegetables, with very little animal or fish protein. There was often a deficiency in calories, in fats and proteins, and in certain vitamins and minerals.

### **WHO activities in 1953**

Two main trends could be seen in the health work of the World Health Organization in the Region, assistance to governments in the strengthening of public-health services and extending and improving educational facilities for medical and related personnel, including auxiliary health workers. These lines of work had been developed to fill needs made manifest by studies and surveys carried out since the Regional Office opened in 1949. In many countries health ministries were at an early stage of their history and the help of experienced public health officers during this expansion period proved important. In addition, training facilities were notably inadequate, especially in public health,

and WHO concentrated on aiding governments to meet some of these needs.

### *Advisory services*

The Regional Office helped governments with advisory health services of all kinds, with visiting technical staff, special consultants who were experts in their particular field, and of missions composed of several highly qualified persons. Public-health officers had been appointed to assist a number of governments, including those of Ethiopia, Iran, Libya, Saudi Arabia and Yemen. Jordan, Lebanon and Syria were served by the Area Representative in Beirut. Two public-health missions, composed of specialists from various countries, spent several weeks abroad, studying government services and making recommendations.

A number of public-health surveys of selected areas in various countries had been made and a health demonstration, based on WHO recommendations, was already in operation in the Qalyub area of Egypt. Some surveys were broad in scope such as a schistosomiasis survey that included Iran, Iraq, Jordan, Lebanon, Saudi Arabia, Somalia, Sudan, Syria and Yemen, and a mental health survey made in Egypt, Iraq, Lebanon, Sudan and Syria. A food hygiene survey was conducted in Egypt, Iraq, Lebanon and Syria, and a nutrition survey had been made in Iran, Jordan, Lebanon and Syria. Most special surveys, however, involved only one country: cerebrospinal meningitis in the Sudan, leprosy in Ethiopia, cholera in Pakistan, nursing in Israel, mental health in Jordan, pellagra in Egypt, ankylostomiasis in Iraq, handicapped children in Lebanon, industrial health and occupational diseases in Egypt, trachoma in Iran, bacteriology in Israel, and hospital services and organization in Egypt.

### *Training and fellowships*

Education was an essential part of the WHO approach to Improving health services. The training of medical and other health workers was accomplished in four ways:

- by developing instructors and administrators;
- by training doctors, nurses, public-health, engineers and sanitarians;
- by granting long-range fellowships for undergraduate studies;
- by training auxiliary health workers as a shortcut to overcoming immediate and serious shortages of personnel.

A number of individual fellowships in undergraduate medicine were awarded to students from countries such as Ethiopia, Libya and Saudi Arabia, where there were no medical schools. Many fellowships for postgraduate study of subjects ranging from anaesthesia to zoonoses were arranged. Twenty-four fellowships to study public health were awarded as well as fellowships to study school health systems.

The total number of fellowships awarded in 1951, 1952 and 1953, and the sources of funds, were as follows:

Year	WHO	Technical assistance	UNICEF	Total
1951	80	6		86
1952	53	52	8	113
1953	147	54	2	203

Seminars were another form of training used, such as a regional eye diseases seminar, a nutrition seminar, a training course in vital and health statistics and a mental health seminar.

### *Maternal and child health*

Demonstrations of methods in maternal and child health, including the teaching of do-

mestic midwifery and minor paediatrics were in progress in number of countries. In addition, WHO helped in the designing and equipping of the Children's Hospital in Karachi, which was financed with UNICEF assistance.

### *Nursing*

The growing realization of the need for really good nursing services led to the appointment of nursing officers to the governments of Lebanon, Libya, Pakistan and Syria. WHO provided instructors for nursing schools and nurses were to be trained in maternal and child health, tuberculosis and sexually transmitted disease projects.

### *Rehabilitation of the physically handicapped*

In Lebanon, a model centre and regional training centre for the treatment and education of physically handicapped children was set up. A physiotherapist and special equipment for a training school for the rehabilitation of poliomyelitis victims was provided for Israel and WHO was associated with a regional centre for the rehabilitation of the blind in Egypt.

### *Disease control*

Malaria-control projects were under way in Iraq, Saudi Arabia and Syria with a successfully completed international project in Iran. DDT for malaria control was provided by UNICEF with Egypt and Pakistan building DDT plants with Technical Assistance funds.

The extent of the schistosomiasis problem in the Region had warranted special attention. In Egypt, a coordinated project that included snail destruction, treatment of cases, health education and environmental sanitation was in progress. New snail-killing chemicals were tried out to determine their relative effectiveness. A similar project combining malaria and schistosomiasis con-

tol was initiated in the Jezirah district of Syria.

The high incidence of trachoma made it the object of special studies, but difficulties were encountered in devising a practical method for mass campaigns.

Sexually transmitted disease control projects were carried out demonstrating control methods and providing training for serologists, nurses, laboratory technicians and social workers.

A leprosy survey was made in Ethiopia in 1950 and, on the basis of the results, a demonstration of leprosy control took place there during 1952.

Tuberculosis was tackled through demonstration and training centres for control of the disease and by BCG vaccination campaigns (financed largely by UNICEF), which were integrated with the work of the centres. A rabies control project was carried out in Israel in 1950, and delegates from 15 countries of the Region attended a rabies seminar in Cooner, India, to learn laboratory techniques.

#### *Public health education*

It was recognized that health education was an urgent need in the Region, and health educators were appointed in a number of countries.

#### *Epidemiological intelligence service*

The Regional Office in Alexandria was one of four centres in the world for the collection and dissemination of epidemiological information and quarantine notifications, which were then transmitted twice weekly by radio in a code compiled by WHO. The Regional Office also settled disputes arising from the application of the new International Sanitary Regulations and collected health data on the *hajj*. WHO aided the equipping and staffing of the new quarantine station at Jeddah, erected by the Saudi Arabian Government.

#### *Public-health laboratories*

To reinforce growing public-health services, aid was given to develop public health laboratories in several countries.

### **The Fourth Session of the Regional Committee, September 1954**

The main message of the Regional Director to the Regional Committee in 1954 was forthright: "Our regional organization has come far in these four years that have, unfortunately, elapsed since the last meeting. It has grown from a promising infant to a quite lusty young adult".

Dr Shousha supplied some interesting information on staff development and how EMRO was meeting its obligations to Member States: "There are seventy-three staff members in the regional office, the more senior of whom are available for assistance to Members; and there are one hundred and thirty-one staff members in the field. Most important is not, however, the actual size of our organization but rather the vast fund of information and experience now available. Whether this experience and information resides in the officers concerned or are available in documents and reports prepared by them or by the array of visiting consultants and missions which have visited the regions, there is no doubt that this body of experience is one of our most valuable and potentially useful possessions. Also, we have all learned much in these years of the techniques of co-operation between an international organization and government members. It is believed that much has been done to stimulate long-range planning, a process very dear to the World Health Assembly, but that with the resources we now have, much more could be done."

The Regional Director's claim that EMRO had developed into a "quite lusty young adult" was amply demonstrated by how the Regional Committee dealt with two thorny issues raised by Dr Shousha. One was the question of long-term planning, as indicated in the above quotation. The other was whether the concept of field work should evolve into a somewhat broader one of regional and multicountry programmes.

With regard to planning, Dr Shousha pointed out that to make long-range plans, countries needed health administrators capable of assuming responsibility for their implementation and that this class of personnel, calling as it did for the highest intellectual and acquired abilities, was in short supply in the Region. In fact, this constituted one of the greatest deficiencies in the Region. He saw great promise in the WHO fellowship programme as a means of overcoming this deficiency. He noted, however, that officers of the right calibre would not be attracted away from the more glittering prizes of private practice unless they could clearly see that they would have reasonable remuneration, security of tenure of office, reasonable superannuation and full-time employment. A number of countries had tried to draw up long-range plans for the development of their health services, and some had partly succeeded. Such plans were important for obtaining aid from international agencies since the more certain such agencies could be that the assistance requested was really necessary and of high priority, was part of a well-considered progressive development scheme, and was, or would be, backed by the necessary financial, fiscal and legal measures, the more certain those agencies would be of granting the required international funding.

Dr Shousha emphasized the changing nature of cooperation and coordination with certain organizations and institutions, partic-

ularly those within the United Nations system like UNICEF and the United Nations Expanded Programme of Technical Assistance for Development (popularly known as the TA programme).

Collaboration with UNICEF had already provided much assistance to governments in the Region, and relations with that agency were closer than ever before.

The Technical Assistance (TA) programme had undergone spectacular development and assumed an importance and organizational complexity much greater than was at one time expected. The result was that its programme was to be, by 1956, based entirely on plans drawn up by the governments of the countries concerned, with the help of international personnel where requested. This meant that ministries of health would be in competition with ministries of transport, agriculture, education, and others, to obtain a proper share of the international aid available from TA funds. The governing body of TA was the Economic and Social Council (ECOSOC), which also controlled the finances. In effect, WHO, like all the other participating organizations, had become a contractor to the TA programme. The Regional Committee could influence the planning at the country level, on which ECOSOC insisted, by coordinating ideas, methods and plans involving more than one country. Dr Shousha foresaw that the role of WHO as a contractor for international health work would become more clearly defined *vis-à-vis* UNICEF, TA and perhaps other international organizations and foundations, and that if the Organization maintained the highest standards in utilizing the skills and funds at its disposal, it would thus be fulfilling the duties specified in its Constitution of directing and coordinating international health work.

Dr Shousha was very prescient also in his remarks on whether the concept of field



work (i.e. projects) should be reconsidered. He foresaw that the content of health programmes might well become less dependent on demonstrations and field projects and focus more on the development of education and training facilities for professionals and auxiliary workers, and that there would be further expansion of regional or multicountry cooperative programmes.

## WHO and UNICEF

### The establishment of UNICEF

The United Nations International Children's Emergency Fund (UNICEF) appeared on the scene at almost the same time as WHO. Although its name was later abbreviated to the United Nations Children's Fund, its original acronym, UNICEF, has remained the same.

UNICEF was built on the foundations left by its predecessor, the United Nations Relief and Rehabilitation Administration (UNRRA). Established in 1941, UNRRA was created to aid countries once the war had ended. Until August 1946, UNRRA had operated what was termed "the most gigantic relief programme the world had ever known". One of the main factors that led to the demise of UNRRA was the appearance of other United Nations agencies.

There was a resolution of the UNRRA Council in August 1946, urging continuation of its feeding programmes for children and specifying that funds left in the UNRRA account at the end of the year should be used for this purpose. The resolution actually proposed the creation of an international children's fund.

Consequently ECOSOC and the UN General Assembly took the necessary steps to establish the International Children's Emergency Fund. A resolution to that effect was made by a plenary meeting of the General Assembly on 11 December 1946.

### Early collaboration between WHO and UNICEF

There was obviously a danger that the two organizations, whose aims overlapped insofar as the welfare of children was concerned, would become antagonistic competitors. Instead, they have turned out to be complementary and have built up a partnership without which the big campaigns against infectious diseases might never have been possible.

In 1958, WHO published a concise summary of its cooperation with UNICEF during the first decade of their existence.

WHO has collaborated with none of the special bodies of the United Nations more closely than with UNICEF. The fund was created primarily for the benefit of children and adolescents in countries which had been victims of aggression and secondarily for child health purposes elsewhere. The fund was formed from assets made available by UNRRA and voluntary contributions from all sources, governmental and private, to be administered by an executive director under policies established by an executive board in accordance with any principles laid down by ECOSOC. With regard to staffing, the resolution called for the utilization, to the maximum extent feasible, of the personnel and technical assistance of existing specialized agencies, in particular WHO.

A full-time medical officer was seconded as an expert adviser in public health, a liaison officer who also served as deputy director of UNICEF's European office, plus a paediatrician, to work with UNICEF. It was also decided that 10% of fellowships awarded by the Commission from UNRRA funds should be devoted to child health. UNICEF's campaign of mass vaccination with BCG also benefited from technical and statistical advice from WHO.

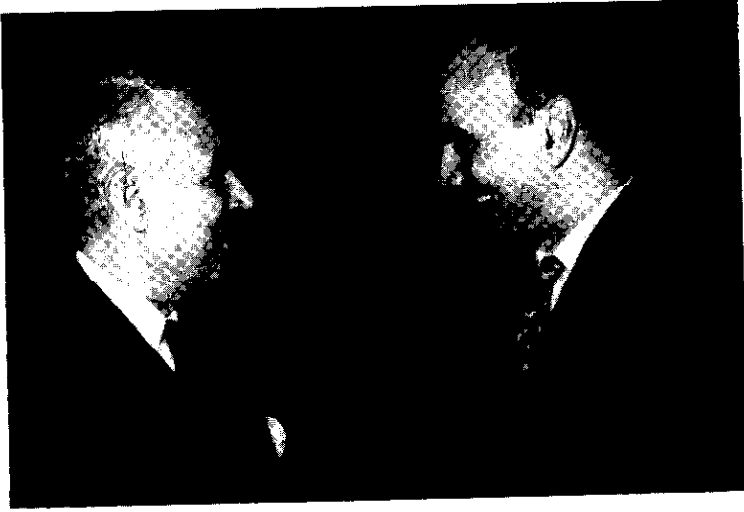
The First World Health Assembly in 1948 found that UNICEF's health projects fell within the competence of WHO and declared

that was ready to handle them as soon as suitable arrangements could be made. It recommended that any health projects financed by UNICEF should be established by mutual agreement between the two bodies and that the implementation of these projects should be regulated by a Joint Committee on Health Policy, consisting of representatives of the Executive Boards of WHO and UNICEF. In 1949, the joint committee defined the principles that should govern the cooperative relationship between the two organizations. UNICEF's role in health programmes is to provide, under its agreements with governments, any required supplies and services, while WHO studies and approves plans for health programmes for which countries may request supplies from UNICEF. WHO is also responsible for making available to governments, at their request, international health experts to help in drawing up plans of operation for UNICEF health programmes or for the implementation of any other health programme. The role of WHO is subject to the provisions of its Constitution and the limitations of its resources; beyond this it will provide services against reimbursement by UNICEF.

These principles were approved by the Executive Boards of both organizations and endorsed in 1950 by the World Health Assembly. The Joint Committee was requested by the Assembly to observe the procedures and ensure that WHO continued to implement in full its technical responsibilities as the directing and coordinating authority on international health work. The same Health Assembly authorized the Director-General of WHO to accept funds from UNICEF for payment of WHO personnel assigned to projects assisted jointly by UNICEF and WHO and to administer such funds in accordance with the staff and financial regulations of WHO.

The Director-General, in May 1950, negotiated with UNICEF an agreement setting forth principles governing UNICEF/WHO staff cooperation. WHO staff members, irrespective of whether they are paid from WHO's budget or from UNICEF funds, are appointed in accordance with WHO staff regulations and are responsible in technical matters to the appropriate offices in WHO. At the same time, senior medical staff assigned to UNICEF headquarters or regional offices should be selected in agreement with UNICEF. International project personnel paid from UNICEF funds should, as a rule, be advisory. It was also laid down that responsibility for the implementation of programmes lay with the administration of the country concerned.

The Fifth World Health Assembly in 1952 approved the principle that WHO should assume, subject to the limitation of its financial resources, responsibility for the employment of any technical personnel needed for future joint activities. The Seventh (1954) Assembly recorded its opinion that the projects which had been carried on by WHO jointly with UNICEF were among the most important activities of WHO and had contributed greatly to the improvement of maternal and child health on a wide basis. The activities undertaken ranged over practically every field of interest to child health—the campaigns for BCG vaccination, the programme for the supply of streptomycin, the campaign to combat syphilis in expectant mothers and children up to 18 years of age, malaria projects, training and fellowship programmes. In later years there were projects relating to tuberculosis (other than the BCG campaigns), maternal and child health, nutrition (in association with the Food and Agriculture Organization of the United Nations), environmental sanitation, health education, aid to hospitals, milk hygiene; plus the control of trachoma, treponematoses and goitre.



**Dr A.T. Shousha (left) and Dr A.H. Taba, the first two WHO Regional Directors for the Eastern Mediterranean**

During the second 10 years of cooperation the UNICEF/WHO Joint Committee on Health Policy continued to give guidance on joint health projects. These projects absorbed, at that time, two-thirds of UNICEF's operational budget (in 1966, for example, 117 health projects accounted for some US\$ 19 million of expenditure). They were divided between maternal and child welfare (about 60% of the total) and disease control, initially malaria, then tuberculosis, yaws, trachoma and leprosy. Poliomyelitis, measles and smallpox also received attention. Other topics discussed by the Joint Committee included the need to strengthen health components in nutrition programmes, a review of the fluoridation of water in connection with dental health and the health aspects of family planning.

### **Continuing and expanding cooperation**

Over the past decades links between the two organizations have grown stronger and joint activities expanded and became more varied.

Earlier programmes have been maintained and further promoted, and new programme areas initiated, such as poliomyelitis eradication, leprosy, dracunculiasis, iodine deficiency control, HIV/AIDS, water supplies, healthy cities and villages, and the strengthening of local health systems.

### **Twenty years after the inception of WHO**

Dr A.T. Shousha was succeeded as WHO Regional Director for the Eastern Mediterranean by Dr A.H. Taba in September 1957. In 1969 Dr Taba, in the *WHO chronicle* 23:220-32 (1969) summarized the achievements of the first 20 years of WHO.

"Since 1949, when the WHO Regional Office for the Eastern Mediterranean was set up in Alexandria, much has happened in the Region. Many countries have gone through the exhilarating experience of political freedom. All but a few have achieved sovereignty or are negotiating for its early attainment,

and new conceptual changes have gone hand in hand with such developments.

"More significant, however, though less spectacular, is what is being done by the Region's emerging countries to give material meaning to their new freedom: how they are shaping their future, making deserts bloom for their growing populations, wiping out disease, and building up their people's health and happiness.

"Definite improvements in health standards have been reported, together with a sharp decline in many diseases. The caravan routes, along which terrible pandemics pursued merchants, pilgrims, and crusaders, are now replaced by airways along which medicine travels to long inaccessible areas. Unresolved problems, however, still face the health services: a widely felt scarcity of medical and paramedical personnel; a notoriously stubborn set of age-old diseases with disconcerting drug-resistant capacities; and a rising tide of organic and mental stresses linked with overnight social changes.

"The Eastern Mediterranean Region of WHO is a tradition-bound area thrust into the main stream of modern life. The twenty-one countries that make up the Region are now engaged in a struggle for space and time: space in which to accommodate a population growing at an average rate of six million a year; time in which to bring the technological advances of the last two decades to bear on social and biological problems that have their roots in the distant past.

"When WHO set out to assist these countries twenty years ago, some were starting practically from scratch, barely able to cope with their most pressing health problems. Others already had a strong legacy of medical knowledge and experience. But all were confronted with many public health problems, including the persistence of certain communicable diseases and an acute shortage of medical and paramedical personnel....

"Malaria is now being fought on a vast scale and its eradication is already foreseeable in almost the whole of the Region. Smallpox eradication through mass vaccination is gaining impetus, the annual incidence having been reduced to a fraction of what it was only ten years ago. The renewed threat of cholera is being countered with further research work and improved control methods. The outlook for schistosomiasis control is brighter since the recent discovery of new drugs and new chemicals. Trachoma prevalence is declining in areas where mass antibiotic treatment is coupled with sanitation measures. Tuberculosis control through BCG vaccination and domiciliary chemotherapy is now an accepted practice.

"The Mecca Pilgrimage, a major annual mass congregation long responsible for widespread epidemics, has been kept free from quarantinable diseases for over twenty years, in spite of an ever-increasing attendance.

"The dark days when one in four children died in the first year of life are over, and several countries report a sharp drop in infant mortality rates since the early nineteen fifties.

"Medical research is no longer exclusive to western capitals: over 40 research activities are supported in the Eastern Mediterranean Region by WHO alone.

"The early, hasty approach to the most urgent health needs has been superseded by long-term health plans closely integrated with overall plans for social and economic development.

### **Education and training**

"The most significant, indeed a revolutionary, change in the Region is the priority being given to investment in human resources.

"Health activities during the past two decades have been characterized and, to some extent, dominated by the training of much

needed medical and paramedical personnel. The number of medical schools in the Region has been raised from 12 to 37, while medical manpower, still critically low in wide areas, has more than doubled. The average doctor/population ratio, despite the rapid population increase, is now one physician to 4500 inhabitants, as against 1:10 000 and more in the early nineteen fifties. Figures in countries vary widely, ranging from 1:400 to 1:30 000. In other words, most Eastern Mediterranean countries are still short of doctors. They are even more short of nurses and medical auxiliaries, though scores of these medium-grade workers have been trained in the Region with the growing recognition of their importance as doctors' "right hands" or temporary substitutes.

"The WHO fellowship programme has done much to help improve the staffing of health services. From 32 in 1949, the number of WHO fellowship awards to health workers in the Region rose to 457 in 1967, bringing the total number to nearly 4000.

"The beneficiaries of these fellowships include 65 young doctors who have already graduated and joined their countries' medical services, 80 more who are still studying and scores of health workers in over 30 different specialities—public health administration, malaria eradication, and nursing heading the list.

"A significant trend is the increasing number of grants for study within the Region, as a result of the efforts of Member States to establish their own teaching facilities and to foster the training of health personnel closer to the community they are to serve. In a Region undergoing swift social change it is interesting to note the growing number of women students among WHO fellows, the proportion having risen from less than 10% in the early nineteen sixties to more than 20% today. A similar trend may be observed in several medical faculties, where up to 14% of students are women.

"All over the Eastern Mediterranean Region, new medical faculties, nursing schools, and training institutions are going up. More teachers are being trained. More textbooks are being published. More training schemes, attuned to local needs, aims, and resources, are being worked out.

### **New health hazards**

"Despite the efforts—many of them backed by WHO—being made in the educational field, the ultimate goal of having sufficient medical manpower is far from being reached. Yet adequately staffed health services are essential if the Region is to cope with the new health hazards arising from far-reaching changes in social life and structure.

"These hazards include: the pollution of air, soil, and water; occupational risks due to industrialization; the squalor, disease and social maladjustments attendant on urbanization; and the impact on mental health of the disruption of tribal life.

"Health services in several countries, including Iran, Lebanon, Kuwait, Tunisia and the United Arab Republic, are reported to be taking systematic steps to assess the problems presented by air pollution, traffic accidents, and housing in their hard-pressed urbanized areas, and to work out remedial measures.

Amazing in their sheer size and complexity "are the housing and sanitary requirements of cities such as Teheran whose population has soared from 600 000 to 3 000 000 in less than twenty years; Karachi, where the number of inhabitants has more than doubled in the same period and is now 2 000 000; and Amman, which has grown from a city of barely 100 000 inhabitants to one of nearly 400 000.

"Hospitals record a growing flow of psychiatric patients from urbanized areas, and the emotional upsets and mental hazards involved are increasingly being investigated

along medico-social lines. The traumatic encounter of rural youths with urban values and the hasty settlement of nomads are already features of concern. But psychiatric care, whether at hospitals or at outpatient clinics, is handicapped by an acute shortage of well-trained workers, which adds much to WHO commitments.

"Nutrition is another problem now being investigated with a growing awareness of the closely interrelated social, economic and medical factors that affect man's health and survival in the Region. The task—no easy one—is to remedy nutritional defects affecting millions and at the same time to provide for six million new mouths each year.

"The rural dispensaries and maternal and child welfare centres that are a feature of the countryside in the Region have many educational and clinical opportunities in this field, while the research work now being carried out by nutrition institutes in Baghdad, Cairo and Teheran is already helping to redress the situation. Dietary and clinical surveys have been conducted, nutritional deficiencies of the vulnerable groups investigated, and local foodstuffs adapted to the needs of weaned children....

"There are also the sanitary fundamentals—adequate supply of potable water, waste disposal facilities, a safe environment, whose eventual attainment is rendered even more difficult by the rapid population increase. Other problems of quite a different type, such as cancer and cardiovascular diseases, cannot be ignored pending the elimination of more basic health problems and already occupy many research workers.

### **WHO-assisted projects**

"The Eastern Mediterranean countries have come a long way in international cooperation in the fight against disease. They have joined in desert development and health promotion projects that should bring unprecedented

benefits to the Region. The achievements of the past 20 years bear witness to their capacity to make further headway. But there is still much to do.

"Over 500 country projects applying modern investigation and control methods have been launched with WHO assistance in remote outposts as well as in teeming metropolitan areas. Some 120 are now in operation and nearly as many are at the planning stage, embracing a wide range of health activities from the fight against communicable diseases to pioneer studies of the hazards stemming from industrialization.

"A great deal has also been achieved through the 100-odd intercountry projects supported by WHO. These projects have done much to coordinate health activities in a Region where intricate national boundaries make close co-operation between health services essential. In addition, the 210 inter-regional projects, mostly seminars and study courses, sponsored by WHO with the participation of countries in the Region, have paved the way for a more enlightened approach to problems ranging from anaesthesiology to zoonoses."

### **A new approach for the Region in 1977**

In 1977, Dr A.H. Taba completed 20 years as Regional Director. During these years there had been many profound changes in the Region. In his report to the Regional Subcommittee, a meeting in Kuwait, he noted that 20 years earlier two subjects had been and remained of prime importance, namely health services development and health human resources development. Though one of WHO's major responsibilities under the constitution is to assist governments on request in strengthening their health services, initially much of the Organization's effort, and a large

part of its resources, had to be directed towards controlling communicable diseases. The special campaigns that were undertaken succeeded in reducing mortality from these diseases, but they did not serve to strengthen the overall health services that were essential for maintaining the gains that had been achieved. By 1977, emphasis had increasingly been placed on building a cohesive network of basic health services in each country, integrating prevention, disease control and health promotion into those health services, and making public health a part of a nation's socioeconomic development and infrastructure.

Creation or expansion of comprehensive health services would normally be a very long process, but in a substantial part of the Region socioeconomic development had raced along at a pace unparalleled, perhaps in any other part of the world. Moreover, owing to the rapid growth of communications and of mass media the educational level of the population had along with standards of living, been rapidly rising.

In this spectacular advance towards better living standards, health had taken a definite place, with a relatively high proportion of the newly available funds being devoted to the improvement of health conditions. Also unique, perhaps, was the spirit of collaboration which existed among friendly countries with generous financial support given by the more fortunate of our countries. Particular mention may be given of the generosity of Iran, Iraq, Kuwait, Libyan Arab Jamahiriya, Qatar, Saudi Arabia and United Arab Emirates, which in addition to their normal contributions to WHO, had curtailed their own demands on the Organization's budget in favour of expansion of activities in other less-favored countries and had made substantial donations to WHO voluntary funds. All this contributed to rapid social development, substantial changes in the patterns of diseases

and major improvements in the resources available for tackling health problems. In terms of health, the advances meant that many countries could begin to formulate long-term national health plans.

Thus, in one respect, the Region seemed to be operating according to pre-health-for-all principles in its assistance to governments in strengthening their health services and promoting cooperation among Member States. In another respect, that of primary health care (PHC), the Region was, even before the Alma-Ata Declaration, already in the "health for all" era and ahead of most of the world. In 1977, the primary health care approach in health services development was accepted in principle by most of the countries of the Region. The challenge was to be able to provide both preventive and curative services that would secure maximum coverage and be adapted to the health needs and social patterns of each community. The Region had witnessed some important milestones in the development of PHC, innovative PHC was evolving in a few countries, particularly in Iran and Sudan, where the emphasis was on protection against disease rather than just provision of curative services, and this within an overall plan for community development. Training of community-based primary health workers was receiving special attention and in some countries, particularly the Sudan, thought was being given to reorganizing the health services in accordance with the primary health care approach.

Recognition was made of the importance of nursing personnel, particularly in rural health care, and of the need to expand nurses' education and to make it more relevant to the health needs of the areas they would be serving. They formed the largest single category of health personnel in the Region. In some of the smaller rural hospitals, nurses constituted the most senior personnel and in commu-

nity services they were often the only health workers available.

The Regional Office, by way of assistance to government efforts to reorganize or expand health services so as to create mechanisms for planning, programming and evaluation, was providing advice on management practices, coordination and the development of national health information systems, including vital and health statistics.

## Smallpox eradication

The eradication of smallpox has been one of WHO's greatest achievements. The First and last reported cases of smallpox were in the Eastern Mediterranean.

It is believed that smallpox first originated in Egypt in the second millennium BCE, as typical smallpox lesions have been recognized on mummies from that era, including that of Rameses V, who died in 1157 BCE. As a consequence of the WHO eradication campaign, the last case of the disease occurred in Somalia, in the port of Merca, in October 1977.

In Pakistan, smallpox, as *Variola major*, was endemic with major epidemics every four to six years. Afghanistan did not maintain health records before 1949, but it was estimated that over a quarter of a million cases of the disease occurred annually. The use of variolation was widespread, and its use persisted until the end of the eradication campaign.

At the beginning of the twentieth century, it was estimated that between 50 000 and 100 000 deaths were due each year to smallpox in Iran, and a substantial number of cases occurred annually up to the early 1960s. There was a similar situation in Iraq. In Jordan, Lebanon and Syria, the disease was brought under control much earlier.

In the Arabian peninsula, smallpox remained endemic until the 1960s, severe epidemics occurring at intervals of a few years. The holy cities of Mecca and Medina provided major foci of the disease, with subsequent exportation to the rest of the Muslim world.

Southern Mediterranean countries suffered from endemic smallpox, with cyclical epidemics up to 1948. Variolation was practised in the countries of the Ottoman Empire from the 13th century, and vaccination campaigns had been undertaken in most of these countries since the 1930s. In the Sudan, *Variola minor* was endemic in the south and east of the country, and severe epidemics occurred from Ethiopia and west Africa when migrants introduced *Variola major*. Extensive vaccination campaigns were practised in most provinces of the Sudan, resulting in a declining incidence and virtual elimination of endemic smallpox by 1962. Ethiopia suffered devastating outbreaks of *Variola major*, which were exported to Somalia by the nomads, but *Variola minor* replaced the more dangerous form from the 1950s onwards.

## The eradication campaign

Following the Twelfth World Health Assembly's resolution in 1959 to embark on the global eradication of smallpox, EMRO took positive steps. The first country to receive WHO assistance in a vaccination campaign was Afghanistan. However, in view of the operational difficulties in this remote mountainous country, the disease was not eliminated until 1972.

Although by 1963 smallpox had been reduced to a low level in Iran, importation of the disease by an Afghan family visiting the holy city of Mashhad late in 1970 resulted in some 2000 cases throughout the country. It spread into Iraq (where smallpox had ceased to be a problem in 1959) and produced 800 cases in 1971, and to Syria, from which the



disease had been eliminated in 1950, but which had more than 50 cases in 1972. The outbreaks were contained by mid-1972. Iran had eliminated all foci by September 1972.

In the Arabian Peninsula, smallpox ceased to be endemic by 1962, apart from Yemen where it continued to be a problem until 1969. Outbreaks followed the importation of cases from India and neighbouring countries and continued to occur in Saudi Arabia and the United Arab Emirates.

In the countries of North Africa from 1948 onwards, improved health services, with vaccination campaigns utilizing liquid vaccine, brought about a great reduction and the eventual elimination of smallpox in Egypt, Libya, Morocco and Tunisia, though Libya suffered an outbreak in 1954 and Egypt in 1959.

Since 1930 Djibouti had experienced only rare sporadic outbreaks following importations, but a countrywide mass vaccination campaign was undertaken as a result of a 1966 outbreak and was continued triennially until 1972, the last known cases of the disease occurring in 1974.

Most countries in the Region, apart from Afghanistan, Sudan and Yemen, had virtually eliminated endemic smallpox over the years and did not require implementation of specific WHO-assisted eradication campaigns.

However, in seven countries: Afghanistan, Democratic Yemen, Ethiopia, Pakistan, Somalia, Sudan and Yemen, programmes were planned, executed and completed with EMRO assistance. This was facilitated by the decision of the Nineteenth World Health Assembly in 1966 to intensify the smallpox eradication programme.

Immediately following the World Health Assembly decision, Dr Ehsan Shafa, Regional Adviser on Smallpox Eradication, was appointed. Separate schemes were drawn up for East Pakistan (now Bangladesh) and West Pakistan. Due to government delays, the pro-

gramme did not start until June 1969 and was not completed until September 1974.

The WHO-assisted eradication programme in Afghanistan did not progress until there were changes in its strategy and structure in January 1969, and apart from some cases imported from Pakistan in April 1973, the disease was eliminated by October 1972.

In Sudan, the reintroduction of smallpox in 1967 and the subsequent epidemics led to increased WHO assistance, with a WHO adviser being posted to Khartoum. A central surveillance team was organized as a national counterpart and following mass vaccination, restarted in 1969, and a surveillance containment programme, transmission of the disease ceased at the end of 1972.

In Somalia, a WHO smallpox adviser took up his post in June 1969, and the vaccination campaign started that year. Between 1967 and late 1972 no cases occurred, but in each subsequent year there were importations from Ethiopia, and in 1976 the disease became reestablished, with over 3000 cases occurring in 1977. An emergency containment programme was undertaken, which was successfully concluded by the end of October 1977, when the last case of smallpox in the world occurred in southern Somalia.

WHO assistance was originally provided to Yemen in 1959, and in 1962 a national vaccination campaign began. No confirmed cases of smallpox were been reported in Democratic Yemen (now part of Republic of Yemen) after 1967, WHO supported, from September 1969.

At the inception of the intensified Smallpox Eradication Programme in 1967, Ethiopia was considered to be strategically important as an endemic country; however, it was only in 1971 that a surveillance system got under way, demonstrating widespread *Variola minor* throughout the country. Millions of vaccinations were performed, and the incidence of the disease decreased year

by year, finally being eliminated in August 1976.

### **Certification of smallpox eradication**

The definition of, and the criteria for, certification of smallpox eradication were developed by a WHO scientific group in 1967 and ratified by a WHO Expert Committee in 1971. A period was laid down of two years of complete absence of smallpox from a country before certification could be considered.

For a number of countries, those on the Mediterranean littoral and adjacent to it, namely Egypt, Jordan, Lebanon, Libya, Morocco, Syria and Tunisia, in which smallpox had ceased to be endemic for many years, certification by an international commission was not required

In the other countries, the international commission certified the following countries as smallpox free, either after a visit or

by correspondence: Afghanistan in November 1976; Pakistan in December 1976; Iraq and the Syrian Arab Republic in October 1978; the Islamic Republic of Iran in November 1978; Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, Sudan and United Arab Emirates in December 1978; and Democratic Yemen and Yemen in June 1979. Because of common boundaries the four countries in the horn of Africa (Djibouti, Ethiopia, Kenya and Somalia) were together treated as one epidemiological entity for the surveillance period 1977-79. They jointly held six-monthly co-ordination meetings sponsored by WHO/EMRO/AFRO, and they were certified smallpox-free at the same time, in October 1979.

Excluding the cost of vaccine, under US\$ 100 000 was expended in total during the eight years (1959-66) by WHO/EMRO in assistance to Egypt, Pakistan, Saudi Arabia, Sudan and Yemen, in anti-smallpox activities.

## **World Health Assembly resolution on the elimination of smallpox**

The Thirty-third World Health Assembly, on this the eighth day of May 1980;

Having considered the development and results of the global programme on smallpox eradication initiated by WHO in 1958 and intensified since 1967;

1. **DECLARES** solemnly that the world and all its peoples have won freedom from smallpox, which was a most devastating disease sweeping in epidemic form through many countries since earliest times, leaving death blindness and disfigurement in its wake, and which only a decade ago was rampant in Africa, Asia and South America;
2. **EXPRESSES** its deep gratitude to all nations and individuals who contributed to the success of this noble and historic endeavour;
3. **CALLS** this unprecedented achievement in the history of public health to the attention of all nations, which by their collective action have freed mankind of this ancient scourge and, in so doing, have demonstrated how nations working together in a common cause may further human progress.

*WHA33.3, May 1980*



**Dr Hussein A. Gezairy, third WHO Regional Director for the Eastern Mediterranean**

In 1967, WHO/EMRO spent nearly US\$ 600 000, and during 1967–79 the funds employed for the Intensified Smallpox Eradication Programme from the regular budget amounted to \$7.6 million, one of the highest regional expenditures. With the use of voluntary funds and other sources, expenditure amounted to \$22 million for the seven countries assisted during 1967–79.

### **Directing the health for all strategy**

Dr Hussein A. Gezairy of Saudi Arabia succeeded Dr A.H. Taba as the Region's third Regional Director in October 1982. Dr Gezairy's election coincided with and engendered a new vision of how the people of the Eastern Mediterranean Region could achieve and enjoy the highest attainable standard of health, which became known in the post-Alma-Ata era as "health for all".

Following the adoption by the World Health Assembly in 1977 of the resolution committing WHO and Member States to health for all by the year 2000 and following the Alma-Ata Declaration in 1978, the World Health Assembly, in 1979, launched the global strategy of Health for All by the Year 2000 and invited Member States to formulate national and regional strategies.

Despite considerable conflict and strife in the Region, the regional and national strategies for Health for All by the Year 2000 were prepared, and the Seventh General Programme of Work (1984–89) was finalized.

In an attempt to minimize the adverse effects of regional conflict on the countries and the peoples of the Region, the Director-General established the Eastern Mediterranean Special Programme (EMS) Office in Geneva. This flexible mechanism enabled contacts to be maintained between countries and the Organization and permitted technical collaboration to continue.

Countries of the Region prepared statements of policy, strategy and plans of action and subsequently started to implement these plans in accordance with their own priorities, strategies and available resources. Progress towards achievement of targets showed a gratifyingly high level of political commitment and active community participation in the cause of primary health care in all Member States.

It was increasingly realized that effective management at all levels was of the greatest importance for national health development if the targets for health for all were to be achieved. A programme for intercountry and national workshops on the managerial process for national health development was launched, and the first workshop was held in March 1983. Improved management was considered an important means of deploying most effectively, and making the best use of, scarce human and other resources. One particular aspect of this was hospital management, which was not well developed in the Region.

WHO subsequently underwent a review of its structure in relation to its new functions. The role of the WHO Programme Coordinator received particular attention in this review, in relation to their playing a more important part at the country level. With more freedom and flexibility being awarded to countries in order that they might make optimal use of WHO resources, the position of the WHO Programme Coordinator had to be further strengthened.

The vehicle which WHO proposed to use for the achievement of health for all was the primary health care (PHC) approach. Wherever possible, activities directed towards the promotion of health were redirected towards primary health care and integrated into a single system for health care delivery. The days had almost passed for major vertical pro-

grammes dealing with single diseases or patient groups.

The comprehensive PHC approach was accelerated in many countries of the Region through technical and material support from WHO, UNICEF, UNDP and UNFPA as well as by other international and bilateral organizations. Considerable progress in coverage was achieved by training community health workers and traditional birth attendants at the first level of contact. Training of supervisors and trainers of frontline health workers also formed part of the systematic approach to continuing training.

The material resource and logistics for health system infrastructure were extended by mobilizing individuals and actively involving the local community. Accessibility to health care facilities was improved as well as the quality of health care, especially for rural and urban underserved populations. The positive reaction from all countries towards better intersectoral collaboration was encouraging, facilitating the reorientation of the existing curative health services and for ultimately achieving the goal of health for all.

At the same time the strong commitment of governments to PHC increased WHO's and UNICEF's obligation to support PHC development more intensively, particularly as through better distribution and utilization of WHO resources PHC would be further accelerated and more effectively implemented. It was evident that greatest difficulties in most countries comprised budgetary shortages, lack of trained personnel and limited development of health systems based on PHC.

Many nongovernmental and international organizations, as well as other UN agencies, were involved in developing primary health care in a number of countries. Important areas under the PHC umbrella were communicable diseases, laboratory services, the

expanded programme on immunization, diarrhoeal diseases, malaria, schistosomiasis, vector biology and control, zoonoses, non-communicable diseases, food safety, health of women and children, drugs, mental health, health of the working population, oral health and last but not least, health of the elderly.

## A change in outlook

In furthering the innovative approaches characteristic of the work of the Region and in order to make health for all a reality Dr Hussein A. Gezairy has been moved by three profound convictions.

The first is that no human enterprise, not even health promotion, can have true meaning without a spiritual dimension, a belief that second to faith, health is the most desirable blessing. Dr Gezairy told the Regional Committee in 1988 "for what would be the gain, in real terms, if all physical needs were satisfied or even glutted, yet the individual lived in a state of moral destitution? This would be the only legacy to pass on to the next generation, on whom the responsibility will rest for ensuring the welfare, if not struggling for the survival, of our planet."

In his 1985-87 Biennial Report he emphasized the spiritual dimension.

In most countries of the Eastern Mediterranean Region, the spiritual dimension plays a considerable role in daily life. The Regional Office has been promoting and initiating activities that will help Member States to gain the active support of religious leaders in transmitting health messages to the communities. A programme that seeks to identify ways in which religious leaders can aid in promoting Health for All was initiated in EMRO. The priority topics were: smoking, water pollution, schistosomiasis, vaccination, the control of infectious diseases, and drug addic-

tion. Smoking was identified as the first of the six priority areas in health to be addressed through concerted activities that were also to involve the media sector. Investigations and research in Islamic jurisprudence were undertaken by a number of "Olama" (Islamic scholars) with regard to the Islamic stand on the issue of the smoking habit. Their "fatawi" (decrees) issued on the subject were used as the basis for producing information and training materials for religious leaders and for dissemination to the public during the planned anti-smoking activities.

In collaboration with the Islamic Organization for Medical Sciences and the Jordanian Royal Academy for Islamic Civilization Research (Al-Beit Foundation), EMRO convened, in 1989, a consultation on Islamic lifestyles and their impact on health development and human development in general. The aim was to contribute to the presentation of this valuable cultural legacy, for the benefit of all humanity. A panel of health professionals, scientists, jurists, religious scholars, educationalists, economists, sociologists, writers, journalists and representatives of the organizing bodies participated. It identified Islamic lifestyles in different areas and verified their relevance to Islam by means of evidence from the Quran and the *hadith*, or traditions of the Prophet. It then studied their impact on health and human development and discussed various ways and approaches for their implementation in today's society. The consultation ended by issuing the Amman Declaration on Health Promotion, which was designed to help in the execution of the identified lifestyles and recommended that WHO/EMRO should undertake the task of coordinating the follow-up process with regard to the implementation of this Declaration.

Dr Gezairy's second conviction is that polite and even friendly cooperation between WHO and Member States must be turned, in the Region, with its unique cultural and spiritual identity, into true and complete partnership.

The third conviction is that basic minimum needs must be met, a subject that has been much emphasized in health for all leadership development. These basic minimum needs include: food, water, housing, sanitation, primary health care, adequate income security, education, and freedom to express spiritual values.

### **The regional health situation today**

The third report of the regional evaluation of the health for all strategy, shows, on balance, that the health situation and the quality of life of the people of the Region has improved during the past decade. Good progress towards achieving the targets set relating to the percentage of gross national product devoted to health; to life expectancy and to immunization was recorded. Progress towards some targets such as the nutritional status of neonates and infant mortality would have been better if it had not been for countries suffering military conflict and economic embargo.

In 1997, in the fields of disease prevention and control, achievements in the elimination and eradication of some diseases continued through active implementation of the appropriate strategies. Fifteen Member States, four more than in 1996, reported zero cases of poliomyelitis. Nine of these countries have maintained this poliomyelitis-free status for three consecutive years. This has been achieved through routine immunization coverage with oral poliovaccine of over 90% and by the conduct of coordinated supplementary immunization activities, in particu-

lar national immunization days, and effective acute flaccid paralysis surveillance as evidenced by high-level performance and accreditation of the laboratories in the regional laboratory network for poliomyelitis surveillance. In war-torn countries and areas, though routine immunization is still very weak, it has possible to organize national immunization days and subnational immunization days and to start surveillance.

The success achieved on the way to poliomyelitis eradication and the continued improvement in routine measles immunization coverage has been behind the Regional Committee resolution to achieve measles elimination by the year 2010. The targets for elimination of neonatal tetanus and of leprosy are also becoming within reach. The Regional plan to address the problems of tuberculosis is progressing rapidly and effectively. In addition to the success in raising public awareness and ensuring political commitment, efforts have been made to strengthen national tuberculosis control programmes, mainly in implementing the strategy of directly observed treatment, short course (DOTS) nationwide by the year 2000. New initiatives in tuberculosis control have included tuberculosis elimination from member countries of the Gulf Cooperation Council by the year 2010, tuberculosis control among refugees and displaced populations, (which are of considerable size in the Region) and the Horn of Africa Tuberculosis Control Initiative. It is hoped that all these activities will soon show dividends in the face of the serious problem of tuberculosis.

Apart from two countries in Africa, the Region continued to be among the least affected parts of the world by the HIV/AIDS pandemic. In addition to their protective sociocultural background, all countries are maintaining effective preventive programmes and improved surveillance. Coordinated efforts with UNAIDS and many other

organizations active in the prevention and control of HIV/AIDS and sexually transmitted diseases (STD) is continuing to halt the spread of these epidemics. Successful efforts have also been made to address emerging diseases with their epidemic potential through improved surveillance systems and development of national capabilities for epidemic preparedness and response.

Despite these achievements, morbidity and mortality from communicable diseases are still of importance. Malaria is still an important public health problem, particularly in Djibouti, Somalia, Sudan and Republic of Yemen.

While communicable diseases are still important, the burden of diseases is doubled by the increasing importance of noncommunicable diseases particularly cancer, cardiovascular diseases and diabetes. One of the main achievements in this field is a better understanding of the epidemiology of the major noncommunicable diseases and the initiation of internationally accepted intervention programmes. Since the main contributors to the increasing prevalence of most of the noncommunicable diseases include certain lifestyles, such as smoking, and changes in eating practices, emphasis has been made in the national programmes towards promoting healthy lifestyles as well as early detection through screening together with other elements such as treatment and palliative care.

The main directions of primary health care are to ensure the provision of equitable and quality essential health care to the people. Institutionalization of the quality of health care is being actively pursued by many countries. EMRO is supporting this welcomed direction through facilitating the development of guidelines, indications and standards as well as supporting exchange of experience in this regard. The basic development needs initiative introduced by EMRO almost a decade ago aims at achieving a bet-

ter quality of life based essential on self-reliance in socioeconomic development supported by coordinated intersectoral action. The catalytic WHO input in initiating this programme is paying dividend as evidenced by the significant inputs being made by Member States towards its replication on a large scale nationally. The most recent example is from Pakistan where billions of rupees have been allocated in the national budget for the extension of the WHO-supported pilot projects over the next three years.

Human resources for health and their efficient performance are a fundamental requirement in all programmes. One of the main efforts which has been vigorously pursued is bridging the gap between health priorities and medical education curricula. Similar efforts are being made to develop effective mechanisms for initiating and strengthening partnership between health authorities, academia and professional associations in support of health for all and also in promoting community-oriented medical education. Efforts to improve the contribution of nursing and other paramedicals to health care delivery have continued through improving the quality of their educational programme.

The Regional programme for self-sufficiency in the production of drugs and vaccines continued to receive EMRO's support, directly through interested donors. Special efforts have been made towards promoting the establishment of national control authorities for vaccines and biologicals, in the same way as has generally been achieved in relation to drugs. There is, however, concern with regard to the potential impact of the World Trade Organization agreements on local drug and vaccine industries.

Continuous improvement of health laboratory services is one of EMRO's top priorities, in order to meet requirements to support medical care and epidemiological

surveillance including that of reemerging diseases and drug resistance. Countries of the region continued to make significant progress in ensuring blood safety from donor recruitment to testing blood and improved blood usage.

In the fields of health promotion, mental health has received special attention. In order to modernize mental health legislations a meeting was held in collaboration with the Islamic Organization of Medical Sciences on mental health legislation in different law traditions including Islamic law.

Reproductive health care has continued to be of high priority. Social emphasis on safe motherhood through the adoption and implementation of the mother and baby package received special attention as an important approach to protect and promote the health of women and children. Adolescent health, occupational health and health of the elderly continued to be given attention and support.

Health education, a main contributor to health promotion and a key element in primary health care is maintaining its multisectoral approach directly through making health information available to the public and through other EMRO initiatives including the school health curriculum. Since religious leaders are among the principal community motivators, EMRO is contributing towards ensuring the right messages by the publication of a series of books, *Health education through religion*, which is receiving considerable publicity as it has so far covered some important issues such as smoking, water and sanitation and health promotion.

Universal salt iodization continued to show its impact on the prevention and control of iodine deficiency diseases and in many countries vitamin A capsules are distributed in conjunction with national immunization programmes. In addition to continued collaboration in ensuring safe wa-

ter supply and sanitation, promotion of healthy cities, villages and communities is gaining momentum all over the Region. The Regional Centre for Environmental Health Activities (CEHA) serves as the technical arm and information exchange unit of the environmental health programme. It has continued its efforts in strengthening national capabilities and in supporting special studies on priority environmental health problems.

In the fields of programme management, EMRO has introduced the Activity Management System. This system has already been reflected in the joint government/WHO programme review missions which have completed the planning for 1998/1999 programmes of collaboration with all Member States.

Efforts are under way in supporting Member States in health sector reform through the introduction of strategic thinking in health planning and management. Enhancing the participation of women in health and development is one of the priority areas given special attention by EMRO in all WHO collaborative programmes. National focal points have been identified and country profiles on women in health and development have been structured and their updating is pursued vigorously.

In the area of health and biomedical information the *Eastern Mediterranean health journal* which has replaced the previous *Eastern Mediterranean epidemiological bulletin* and the *Health services journal* has taken over the basic responsibility of exchange and dissemination of information among the scientific and public health community. So far this journal has been received with considerable enthusiasm and encouraging feedback has been received from the scientific and academic community. Several publications and documents have been issued by EMRO in the main languages of the Region. We are pleased to note that the unified



medical dictionary has been carried through the final stage and that it will soon be available on CD-ROM.

## Anticipating the future

The best conclusion for this historical overview is to quote the introduction written by Dr Hussein A. Gezairy, Regional Director, to his annual report on the work of WHO in the Region during 1997. The introduction was both the Regional Director's concluding remarks on the first 50 years in the life of WHO, as well as a forward look at the prospects for the years to come.

In his introduction Dr Hussein A. Gezairy said:

"It is with both pleasure and great optimism that I introduce my report for 1997, which represented the last of the first 50 years of WHO. Pleasure that we have been able to achieve so much together for the future of our nations, and optimism that our efforts will continue and grow to meet the new challenges that will surely arise in the next 50 years.

"And yet, at the same time, so much remains undone. It is appropriate that the World Health Day theme for this fiftieth year, 1998, should be safe motherhood; appropriate and at the same time of concern that it is still necessary to draw attention to the health needs of the very people who bring us into this world and upon whose care and devotion we depend for our own survival—mothers. It is true that there are countries in the Region where the maternal mortality rate has fallen over the years to a level comparable with the best rates in the industrialized countries. I am proud of this progress and so should those countries be proud. Nevertheless, we should not forget that many other countries have not been successful in tackling maternal mortality. Three countries in

the Region, Afghanistan, Somalia and the Republic of Yemen, have among the highest maternal mortality rates in the world.

"There are a number of strategies which have proved successful in tackling this problem, among the most important of which is birth spacing. Good spacing of pregnancies, which also means a limited number of pregnancies, is perhaps the most important intervention. There is no one ideal model of family planning. What is important is political commitment, not only to ensuring reproductive health care within the context of primary health care, but more importantly to ensure improved literacy and education among women and girls. The more educated a woman is the more likely she is to seek help at an early stage and to demand good services from the system. In order to have control over such decisions women must have the social power to have a say in planning their families, supported by a health and education system that provides them with the means to do so. Above all, the strategy must have the support and conviction of society and it must be appropriate to local values. This means that those who influence opinion and direction in society must be convinced of its rightness and carry the opposition with them.

"Safe motherhood also requires trained health personnel to provide the necessary care for pregnant and delivering mothers. Some years ago, the thirty-fifth Regional Committee urged Member States to ensure the availability of at least one trained birth attendant in every village. This remains a valid and indeed essential requirement for safe motherhood in rural areas. It is a simple and relatively low cost strategy that can have inordinate impact on maternal mortality and morbidity.

"Addressing the issue of female genital mutilation, so-called female circumcision, is also important to safe motherhood in some countries. Such tampering with the fe-

male body has profound physical, psychological and sexual impact on women and I applaud the courageous stand of the Ministry of Health in Egypt in pursuing the cause of women in this regard. The Regional Office has been actively involved in combating the practice of female circumcision in the Region and has supported governments in their efforts to convince people of the lack of a health or religious basis for this terrible practice. In order to help combat the misconceptions surrounding a religious or health basis for female circumcision the regional publication on circumcision, in the Health Education through Religion Series, is now available in all the spoken languages of countries where this practice is prevalent.

"The cultural and religious heritage in this part of the world supports equal rights and opportunities for women and yet, with time, many of these rights have been eroded by society and by governments. It is now generally recognized around the world that the exclusion of women from involvement in decision-making processes is detrimental, both in regard to their own health and indeed to all aspects of health and development in a nation. Now is the time, as a new millennium approaches, for this to be addressed with greater commitment in our Region also. Women are involved at the highest government levels in several countries of the Region but there is still a long way to go. That a substantial proportion of females in some countries in the Region still do not enjoy some basic human rights, such as access to and equal opportunity in education, health, nutrition, income generation and security, should be of concern to us all.

"I am pleased to be able to report on the continuing progress in eradication of poliomyelitis. A major breakthrough in 1997 was the success in carrying out, for the first time, national immunization days in Somalia and in south Sudan. This was in addition to our con-

tinued success in other countries facing significant difficulties, including Afghanistan and the Republic of Yemen. The fact that many previously unreachable children are reached during national immunization days has drawn our attention to the need to make use of these chances to deliver other vaccines and micronutrients, particularly vitamin A.

"The basic development needs initiative has made immense progress in the Region this past year. In Pakistan, following success in demonstration projects supported by WHO, the Government has now incorporated the approach into its national programming and is planning to expand implementation throughout the country. This is the first such institutionalization of a basic development needs programme and promises much for the future of health development in Pakistan. I look forward to a similar process taking place in other countries. Meanwhile the Regional Office is in the process of developing a monitoring and evaluation process specifically for this approach.

"In this changing world, now so dominated by the concept of the free market and by international agreements that will affect us all profoundly, especially the World Trade Agreement, the need for health sector reform continues to gather momentum in the Region. At same time we must beware of the potential pitfalls we may face in reform. The need to contain cost and increase efficiency, and the trend towards increasing reliance on a free market in health, will increase the cost of treatment for very many. Thus, those that can afford the treatment they need will get it and those that cannot may be prevented. Safety nets must be in place, both for the poor and to ensure that cost does not spiral out of control for those that can currently afford it. I wish to emphasize here that health is a human right and it remains the responsibility of governments to cover those who do not have access to health services, while ensuring that

those who have access currently continue to have access. Many countries are considering the introduction of health insurance under the impression that this will reduce the cost to government, however experience around the world has shown that this is not necessarily the case. Moreover, certain aspects of health care, such as preventive services, must continue in the government domain and freely available to all the population. In this regard I am pleased to note that all agencies supporting national development programmes, including the World Bank, are now convinced that development of any kind is not sustainable without health development.

"In parallel with health sector reform at a national level, reform is also being considered and implemented in WHO. This is a very natural and healthy move for WHO's revival but, as with all reform movements, not devoid of problems. A particularly significant aspect of this reform is the distribution of

the regular budget allocations to the Regions which has been reconsidered by the World Health Assembly for the first time since the Organization was established. It is appropriate that this should happen at the commencement of this new era of our existence. It is also timely given the changes that have taken place in the world in the past 10 years and the changing needs of various populations in order to promote equity and solidarity between Member States. However we must be prepared to address the impact this proposed reallocation will have on our own Region and strive to ensure that resources continue to be directed towards priority areas and those most in need.

"Finally, I wish in this anniversary year to extend greetings and thanks to all those who have contributed to our collaborative programmes, past and present. I look forward to the continuation of our efforts to achieve and maintain health for all."