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SUB-COMMITTEE A

Agenda item 12

REPORT OF SUB-COMMITTEE A

OF THE

TWENTY-SEVENTH SESSION

OF THE

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

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PART I

INTRODUCTION

1. GENERAL

Sub-Committee A of the Regional Committee for the Eastern Mediterranean at its twenty-seventh session met in the City of Kuwait from 10 to 13 October 1977. The inaugural meeting was held at the Kuwait Telecommunications Centre, and subsequent meetings at the Kuwait Hilton Hotel. Five plenary meetings were held. Technical Discussions on "Health education with special reference to the primary health care approach" were held on Wednesday, 12 October.

The following Member States were represented:

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

All Member States represented exercised their right of vote in Sub-Committee A.

The session was also attended by representatives of: the United Nations Development Programme, the United Nations Children's Fund, the United Nations Relief and Works Agency for Palestine Refugees, the Organization of African Unity and the League of Arab States, an observer from the Palestine Liberation Organization, and representatives or observers from sixteen intergovernmental, nongovernmental, and national organizations.[1]

2. OPENING OF THE SESSION: Agenda item 1

In the absence of the Chairman of Sub-Committee A of the twenty-sixth session of the Regional Committee for the Eastern Mediterranean, the session was declared open by H.E. Dr A.R. Al Awadi, Minister of Public Health, Kuwait, and Vice-Chairman of Sub-Committee A of the 1976 session.

[1] A complete list of representatives, alternates, advisers and observers attending the session is attached as Annex II.

3. ELECTION OF OFFICERS: Agenda item 2

The Sub-Committee elected the following officers:

Chairman:	H.E. Dr Abdul Rahman Al Awadi (Kuwait)
Vice-Chairmen:	H.E. Dr Ali M. Fakhro (Bahrain) H.E. Dr Ibrahim Badran (Egypt)
Chairman of Technical Discussions:	H.E. Dr Hussein Al Gazairi (Saudi Arabia)

4. INAUGURAL ADDRESS

H.E. Dr Abdul Rahman Al Awadi, Minister of Public Health, Kuwait, welcomed participants on behalf of H.H. the Ruler of Kuwait and of H.H. the Crown Prince and Prime Minister.

Kuwait was fully aware of the importance of the Regional Committee's meetings, which enhanced mutual understanding and made a valuable contribution towards solving health problems for the welfare of humanity. The Region, with its ancient tradition, had once led the world; it should now revive that glory by serving as a model in health matters.

Among present-day health problems were the diseases of civilization including the psychological problems associated with rapid economic growth. The outbreak of cholera in the Region was causing anxiety,and the related problems of inadequate human waste disposal and personal hygiene remained. WHO, under the leadership of the Director-General and the Regional Director, was working to overcome those and other problems as part of the Region's overall socioeconomic development.

Dr Al Awadi drew attention to the plight of the Palestine people, condemned to live under poor health conditions in refugee camps. The world community should help to restore their legal rights and ensure that they return to their lands.

He wished the Sub-Committee all success in its work for the benefit of the health of the peoples of the Region.

5. ADDRESS BY THE DIRECTOR-GENERAL

Dr H. Mahler, Director-General of the World Health Organization, said that the last World Health Assembly had indicated WHO's main direction when it had decided that the principal social target of Member States and WHO in health should be the attainment by all the citizens of the world, by the year 2000, of a level of health that would permit them to lead socially and economically productive lives. Social justice demanded that until they reached that level, individual health care should not be provided beyond what could be afforded for the population as a whole. Each

society must determine what was essential, in keeping with its social expectations and economic capacity. He suggested, as minimum indicators of achievement, an infant mortality rate of less than 50 per 1 000 live births and a life expectancy at birth of more than 60 years.

Most of the programmes required for the attainment of health for all were already known. The first was primary health care. Others included adequate food and housing, with protection of houses against insects and rodents; water supplies adequate to permit cleanliness and safe drinking; suitable waste disposal; services for the provision of antenatal, natal and postnatal care, including family planning; infant and childhood care, including nutritional support; immunization against the major infectious diseases of childhood; prevention and control of locally endemic diseases; elementary care of all age groups for injury and diseases; and easy access to sound and useful information on prevailing health problems and the methods of preventing and controlling them.

Primary health care was no second-rate substitute for something better, to be applied only in developing countries. Even highly industrialized and medically affluent societies had come to recognize the need to reinforce their primary health services if they were to provide their total population with effective health care at a price they could afford. It was true that there was a danger of primary health care being abused, minimum resources being allocated to it in a politically lukewarm or condescending manner. However, if countries were vigilant and ensured that communities were fully involved in developing the care that was appropriate for them, there would be no abuse.

For communities to be intelligently involved, they must have easy access to information on the health technologies available, their advantages and disadvantages, and their costs. That was the essence of a new type of health education, which gained the confidence of individuals and communities by explaining health technology in a language they could understand so that they could participate genuinely in shaping their own future - a replacement of passive health education by active health learning.

Primary health care, however, could not be effective alone; it had to form part of a broader health system, and the other components of that system must be organized in such a way as to support its needs. That was one dimension of the filter-inwards process whereby problems of the periphery should determine the content and organization of the more central levels of the health system; unfortunately, the opposite usually held true.

For many years, communicable diseases would continue to be a major health hazard for most countries of the Region. To combat them, action had to be initiated according to the best available epidemiological information. The measures taken would then yield more precise information, but it would be futile to postpone action until a highly accurate and comprehensive nationwide epidemiological analysis had been completed. The means that had proved themselves in the past must be used, while research was pursued to find more fundamental solutions. Those means were familiar: the provision of water, and in particular safe drinking water, sound liquid and solid waste disposal, housing hygiene, vector control, food hygiene, immunization, chemoprophylaxis and chemotherapy. However, the optimum blend had to be sought, and they had to be systematically and continually applied. If the existing health system was

inadequate, the integration of communicable disease control activities would serve to strengthen it. Again, however, the start should be made within primary health care, thus helping to shape appropriately the health services and institutions at more central levels. Most countries had miserable political and operational records in that respect.

Two types of research were required to strengthen the prevention and control of communicable diseases in the Region, the first aimed at generating new knowledge and the second at applying existing knowledge. The WHO Special Programme for Research and Training in Tropical Diseases was particularly concerned with the first category and was highly relevant to major health problems in the Region. The search for new ways of dealing with hostile environmental factors, improved methods of vector control, new drugs, simple diagnostic tests, and new or improved vaccines must take place in the countries where those diseases were rampant. Since research resources were finite, if this international collaborative programme was to make progress, such countries would have to give it much higher priority than other research topics more appropriate to countries in which communicable diseases no longer played a significant part. However, if this type of socially relevant health research became additional to, instead of replacing, the conventional medical research now being carried out there, it would only add to the existing contradiction between modern medicine and health.

It was equally important to ensure the thorough application of existing knowledge as well as the immediate application of new knowledge as soon as it had proved its worth. That required a pragmatic research approach making commonsense use not only of technical knowledge, but also of managerial knowledge, operational research methods, and social, cultural and economic analyses. Health systems research of this type deserved much greater attention from national health managers, who could use it for the direct solution of practical problems concerning their health systems. Theoreticians should not be allowed to dictate sophisticated methodologies that had not been rigorously tested. The indispensable ingredients for successful health systems research were tough operational discipline combined with the political guts to use the information generated.

Immunization against common diseases of childhood was another high priority programme. The Thirtieth World Health Assembly had pointed the way when it had adopted a resolution aimed at ensuring that by 1990 all the children of the world would be thus immunized. Episodic mass campaigns had not proved effective. Programmes had to be established permanently, and here again it was necessary to use the primary health care system. In most countries, however, that would require a government decision, because the supply of vaccine depended on purchase and production policy, and the support of the more central echelons of the health system was needed to ensure the timely supply of potent vaccine. Regional self-reliance in vaccine supply would entail reaching agreement on the selection of countries for producing various types of vaccines, the location of laboratories for quality control, and the control of imports and exports. WHO's neutral offices were at the Region's disposal to help in that regard.

Dr Mahler convinced that the Region, which through its heroic efforts, in spite of a temporary local setback, was on the threshold of eradicating smallpox, would soon be able to give communicable diseases much lower priority if existing knowledge was properly applied.

The Region could not neglect the care of diseases such as cancer and cardiovascular diseases, nor forego, for example, the promotion of mental or oral health. However, realism must be the keynote. As the industrialized countries had learned, there was no limit to investment in these areas, whereas the health dividends were usually far from certain. Fundamental health technology had to be developed and applied, leaving palliative and placebo technology to those whose way of life demanded them. Methods should only be used when shown to be effective by rigorous testing, and on condition that the country could afford them within a policy of social equity. To concentrate on trying to prevent this category of disease wherever it could be prevented - for instance by environmental control, or community action to change life-styles - and then to offer types of medical care whose cost-effectiveness had been proved was not to provide second-class solutions. On the contrary, it was better than the approach of the medically affluent societies. Here a vast area of health systems research awaited those who were sufficiently enthusiastic to accept the challenges.

The Director-General drew the Sub-Committee's attention to the importance of the search for more appropriate health technology. In many countries the health professions had become the slaves of technology, and it was in their own interest to search for technologies that they could master. Certain countries had experienced great difficulties in using doctors in rural health centres, not only because of their reluctance to go there, but mainly because they were unfit to provide front-line medical care without the sophisticated electro-medical apparatus on which their training had made them dependent. WHO had launched a programme aimed at developing health technologies that were both socially and technically acceptable. The programme could only be useful if countries first reviewed their own situation, identified the technologies that needed to be revised, and then applied their research capacities to find appropriate solutions. WHO could collaborate by taking part in the research and arranging the exchange of information among the countries concerned.

Drugs were inseparable from health technology, which had become unduly drug-dependent. Health services must work with fewer drugs if they were to master the health situation. A recent WHO scientific consultation, based on country visits, had concluded that some 150 essential drugs could meet the vast majority of health care needs. If countries wished to free themselves from drug colonialism, they should work to ensure that these essential drugs became available to all who needed them. To do so would mean formulating new national policies concerning the manufacture, quality and price control, import and export of the drugs. Collaboration within the Region as well as with other Regions was needed to promote the orderly growth of self-reliance in drug matters.

Another aspect of technology in urgent need of change related to basic sanitary measures. WHO was committed to participating in the global effort to attain the target adopted by Habitat, the United Nations Conference on Human Settlements, to have "Water for All by 1990". Experience had shown that safe water supplies and sanitary waste disposal could be provided through low-cost technology making maximum use of local natural resources, manpower and material. The barriers to the adoption of that approach were more psychological than technical, due both to a false idea that the solution proposed might be inferior and to an inability to mobilize people's participation. Attitudes must be changed, because in many areas of the Region it was the improvement of water supply together with proper nutrition that would have the greatest impact on the prevention of disease and the improvement of the quality of

life. Here the health sector, though only one of many concerned, had a major role to play. WHO was ready to intensify its collaboration wherever needed within countries, and at regional and global levels, whether for the development of low-cost appropriate technology or to attract multilateral or bilateral sources of funds.

Malnutrition was probably the single most important health problem in developing countries. The national and international health sectors must now accept their responsibilities, define realistic policies and strategies, generate appropriate technologies, and formulate applicable programmes. Effective and realistic nutritional activities should be a cornerstone of primary health care. The knowledge was available but the political will and social imagination to apply it were lacking.

In addition to programmes and systemsfor their implementation, people were needed to conceive and deliver the programmes and manage the systems. That was crucial to the attainment of health for all, by the people and for the people. In acquiring greater self-reliance in health, the people required the stimulation and guidance of health workers who were also of the people. The Region could not continue for long to import professional health workers; instead, it must invest more in generating new human resources for health. Major advances in the attitudes and actions of professional health workers could only be made when their education and learning were attuned to the social needs of populations, and not to the technical dictates of professionalism. The principles for so doing had been evolved in all WHO's deliberative organs.

Action for change must now start within countries, where the practical constraints lay - lack of awareness of the scope and depth of the problem, conservatism, overdependence on the medical mystique, and the opposition of the health professions to interference in their sacred domain.

If countries started to diversify their health manpower in the light of social needs, and to revolutionize their education and learning practices, WHO would be in a much better position to provide the necessary support as well as to attract the necessary funds. Fellowships could be used in a totally different way so that they served first and foremost the newer manpower needs and were provided almost exclusively within regional mechanisms. He believed that the Regional Committee should make a policy evaluation of what he considered to be disastrous inertia in the health manpower field, though the Eastern Mediterranean Region had a creditable record as regards collaboration in that field.

As a mechanism for health development, the Director-General stressed the establishment of a centre or a network of centres to serve the Region for operational research, development and training in specific programme areas. Countries could then work together to solve common problems and to build up cadres of national personnel trained in such a way as to achieve self-reliance in developing specific programmes in their own countries. For example, the best way to foster and improve country health programming was to establish regional centres for operational research, development and training in that process. The same applied to the development of appropriate low-cost technology in various fields. He also drew attention to the catastrophic lack of properly trained health care managers at all levels. Unless intercountry and country programmes in this area were started quickly the Organization's call to achieve Health for All by the Year 2000 would fall on the deaf ears of traditional medical bureaucrats.

Dr Mahler was confident that with the delegates' support political obstacles could be overcome. WHO was eager to work with governments in developing the programmes and establishing the mechanisms required to reach the target. It could do so within countries, if they wished, in addition to providing regional and global support. But WHO belonged to its Members and it was they who must give the political impetus and support to convert the blueprint for health action into action itself. In turn, the Organization would do its utmost to help to achieve health for all in all the countries of the Region and the world.

6. ADDRESS BY THE REGIONAL DIRECTOR

Dr A.H. Taba, Regional Director, on behalf of the World Health Organization, welcomed those present to the annual session of Sub-Committee A of the Regional Committee for the Eastern Mediterranean. He thanked the Government of Kuwait for its generous hospitality in acting as host to the meeting and for the warm welcome all had received.

WHO's active association with Kuwait went back to its creation as an independent State in 1960. The traditions of dynamic leadership established by H.H. the Ruler of Kuwait, who had himself been the first Minister of Health, had been admirably followed by his successors. The developments in Kuwait's health services had kept in step with the country's unparalleled socioeconomic development, much being owed to the present Minister of Public Health, who formerly, as a senior technical officer in the Ministry, had contributed so much.

One of the features of the Region, which included some of the richest countries in the world as well as some of the economically less fortunate, was the extent to which Member Countries assisted each other. In recent years, the generous attitude of the better-off countries towards their less affluent brethren had been gratifying. At the same time, the technical co-operation that existed between Member Countries was greatly and mutually appreciated. WHO, as the co-ordinating authority for international health in the world, was proud to play its part in ensuring that this collaboration was as effective as possible.

Referring to WHO's high priority work in the education and training of health personnel, he noted that all countries of the Region were moving steadily forward to achieve sufficient health manpower, adequately and relevantly trained to meet the needs of the national health services.

During its 1976 session, at the outcome of its Technical Discussions on this important subject, the Sub-Committee had passed a resolution requesting him to convene a high-level consultation on the relationship between educational institutions responsible for training health personnel and Ministries of Health and other agencies responsible for health services development, with a view to achieving closer coordination.[1]

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[1] Resolution EM/RC26A/R.12.

The Ministerial Consultation on Health Services and Manpower Development, arranged in response to that resolution and to which he had invited all Ministers of Health, Education and Higher Education, as well as key senior policy-makers from ministries, universities and other training institutions, had originally been planned for the week after the Sub-Committee's session, in Teheran. Although it had had to be postponed, he hoped to reconvene it in 1978.

The Consultation would be, at one and the same time, an attempt to tackle the crucial issue of co-operation between the "producers" and the "consumers" of health personnel, and a new type of forum for the discussion of such issues.

The postponement of the Consultation was related to the reappearance of cholera in the Region, which was causing concern to several countries. However, cholera - grave affliction as it was, and tragic as were the deaths it had caused - need no longer be either the major tragedy nor cause for crisis it once had been. The salutory experience of the recent outbreaks should lead to renewed efforts in basic public health to ensure a healthy and clean environment.

The concern caused by the cholera "scare" also reflected the need for redoubled efforts in health education of the people. A document on this subject would be presented during the Technical Discussions session, and Dr Taba stressed the vital need to bring real awareness of present-day health problems to all through frank and involved mutual discussions with the people. For health education to be effective, all available resources, including those of other professions than those of health, and of the social and behavioural sciences, must be brought to bear on the problems.

WHO was fully prepared to work with Member Countries in these fields; such co-operation, however, could only succeed through consultation. Consultation, indeed, was one of the main purposes of the present session of the Region's governing body, which the Regional Director was confident would discuss broad issues and provide guidance on technical and policy matters in the friendly and harmonious way that had always characterized its annual meetings.

7. ADOPTION OF THE AGENDA: Agenda item 3 (Document EM/RC27/1 Rev.1)

The Sub-Committee adopted its agenda as presented, with the addition of two sub-items under agenda item 11 (Other business): (a) Arabic text of the WHO Constitution; and (b) The cholera situation in the Eastern Mediterranean Region.

8. APPOINTMENT OF THE SUB-DIVISION ON PROGRAMME: Agenda item 4

The Sub-Committee noted that at its 1977 session it was required only to discuss revisions to the regional programme budget for 1978 and 1979, which had been approved in 1976. It therefore decided not to follow its usual practice of appointing a Sub-Division on Programme.

PART II

REPORTS AND STATEMENTS

1. ANNUAL REPORT OF THE REGIONAL DIRECTOR: Agenda item 5 (Document EM/RC27/2)

Introducing his report, Dr A.H. Taba, Regional Director, noted that in keeping with the generally satisfactory and sometimes spectacular socioeconomic progress achieved during the year in the Region, health had not been neglected. Emphasis had increasingly been placed on the need to build up a cohesive network of basic health services in each country, integrating programmes for prevention and health promotion, and giving the total public health programme due attention within the wider national programme for socioeconomic development.

Many countries had formulated a national health plan, overcoming the problems usually met during implementation and management, using the country health programming approach. That approach was a simple and flexible procedure, essentially a national effort assisted by WHO as required, and adaptable to the local socioeconomic situation. Top decision-makers and programme managers from Ministries of Health and other departments of Government were involved. WHO had assisted Afghanistan, Pakistan, Sudan and Yemen in formulating their country health programmes, and similar exercises would soon start in Democratic Yemen, Iraq and Somalia.

WHO and national authorities had continually sought to improve the methodology used for country health programming and to ensure more effective delivery of health services. In Sudan and Pakistan, the second stage of the programming process, project formulation, had been carried out by a core of suitably trained national staff. In Yemen, the country health programming approach had been used not only as the basis for the first national health plan, but also in the reorganization of the Ministry of Health.

Despite the progress in the expansion of health services, in large areas of the Region the population remained either underserved or with no access at all to adequate health services or medical care. The goal of governments was to provide basis health care coverage for all the population, urban and rural. The primary health care approach was now accepted by most countries of the Region, with the aim of providing comprehensive health services, both preventive and curative, and securing maximum coverage adapted to the health needs and social patterns of each community and involving the community in the design and operation of the services provided. Health was now recognized as an integral part of community development in most countries and innovative approaches in primary health were evolving in a few, particularly Iran and Sudan, where comprehensive health services were provided within the overall plan for community development. Training of community-based health workers capable of offering both curative and protective services under close supervision was receiving particular attention.

WHO was shortly to organize two meetings in the Region on primary health care. The first, an inter-agency meeting arranged in close collaboration with UNICEF, and

with the participation of other international and bilateral agencies, was being held in Alexandria later in October 1977. The second, to be held at the Regional Office in early 1978, would be a regional seminar with the participation of all Member States. Dr Taba hoped that the meeting would not only promote the application of the primary health care approach in the Region, but also constitute a regional input to the International Conference on Primary Health Care scheduled to meet in Alma Ata, USSR, in 1978. WHO had also established a Regional Advisory Committee on Primary Health Care, bringing together selected individuals involved in the methodology and management of primary health care programmes.

With the expansion of health services, the need for adequately trained health manpower needed no emphasis, and Dr Taba pointed out that the regional programme in that field had been referred to in some detail in his Annual Report. WHO had persistently maintained, with the full support of Member States, that the best possible investment of WHO funds and efforts was in the training of health workers, in accordance with the determined needs of the countries. Not only was there a need for more health workers of all categories and types, especially auxiliary and middle-level personnel, but the necessity to improve the quality of national health personnel and the relevance of their training to local needs remained paramount.

The Region's fellowship programme continued to contribute effectively to that aim. Over 600 fellowships had been awarded in 1976, about one-fifth of them to teachers in the various branches of health sciences. Increasing numbers of fellowships were regularly awarded for training within the Region and that trend would continue as educational facilities developed, particularly at the level of postgraduate and continuing education. Teacher training remained one of the main focuses, and critical masses of teachers were being trained in educational planning and technology. Since the inception, in 1972, of the WHO Regional Teacher Training Centre at the Department of Medical Education, Pahlavi University, Shiraz, Iran, over 900 teachers of medical and other health professional schools had been exposed to intensive workshops and courses organized either at the Centre itself or elsewhere in the Region with the help of its Director and staff; thus, steps had been taken towards a degree of self-sufficiency in many of the national educational institutions for health professionals.

Training of teachers, and the concomitant revision or adjustment of curricula, had proved effective in guiding national efforts to expand schools for health professionals. The result had been an impressive increase in the number of these schools in the Region, as was shown in Figures 1, 2, 3 and 4 in the Annual Report. More important was the increasing extent to which the health professional schools were now preparing the type of health personnel the countries most needed. Partially as a result of its earlier educational successes, WHO was providing fewer and fewer long-term field staff and making greater use of national talent in WHO-assisted projects.

Dr Taba summed up some of the crucial problems with regard to the programme of health services and manpower development in the Region. First, there was an overall shortage of all categories of health workers. Secondly, there were too many of some types of health workers, such as physicians, in relation to others. Some highly educated health workers (physicians, nurses), did tasks that could be successfully performed by much less elaborately educated health workers. The available health workers were not well distributed in terms of the needs: too

many were in towns, and not enough in rural areas. Moreover, a large portion of national health budgets was spent on hospitals and sophisticated care, even though the authorities were aware that promotive and preventive health efforts had been found more effective.

Those problems were largely due to the absence of an adequate health manpower policy, based on an appreciation of local resources and needs. Under item 9 of the agenda, a regional medium-term programme for health manpower development covering the years 1978-1983 (document EM/RC27/4) was being presented. This was a first attempt to introduce sequential planning over a period of years in one of the Region's major programme areas and to design the planning in such a way that the outcome of activities could be effectively evaluated.

Meanwhile, in recent years persistent efforts had been made, in collaboration with the national health authorities, to improve all aspects of health manpower planning, and in particular to ensure that there was an effective and close relationship between the education and training of health personnel and the planning and design of the health services for which they were being prepared. In fact, the health services and manpower development concept aimed at promoting an integrated development of health services and health manpower, and at co-ordinating the components of production of relevant and needed manpower and the utilization of that manpower within the health services.

In that connexion, the Regional Director referred to the Ministerial Consultation on Health Services and Manpower Development, which had originally been scheduled to meet in Teheran in the week following the Sub-Committee's session, but had been postponed at the request of a number of Ministers of Health because of the cholera outbreak in the Region. The Consultation, now planned for early 1978, would be a further effort to move towards ever closer collaboration and co-ordination between the Ministries of Health and those in charge of the education of health personnel. The Consultation should help in reorienting the pattern of education in traditionally-minded training institutions to ensure that their products were of most use in the health services.

Communicable diseases had tended to decline in importance in the Region. In the last quarter of 1976 an international commission of experts had certified that smallpox had been eradicated from Afghanistan and Pakistan. In Somalia, which had been smallpox-free since 1974, an importation in August 1976 had resulted in an outbreak in Mogadishu and 39 cases had been diagnosed up to January 1977, following an intensive search. Five cases had also been diagnosed in Kenya. Search operations had been intensified with the help of WHO epidemiologists in Somalia and Kenya, and, by the end of May, ten regions in South Somalia had been found to be affected. A total of 3 161 cases had so far been reported in 1977. Since the end of June, outbreaks with active cases had steadily decreased. In northern Somalia, joint national/WHO searches in the June-August period had revealed no smallpox transmission in the five regions. WHO assistance now included 24 epidemiologists and operations officers, together with local cost expenditure, while about 3 000 national staff and 50 vehicles were engaged in surveillance and containment. The recent steady fall in cases and outbreaks suggested that transmission could soon be interrupted.

A meeting in Nairobi in September, attended by representatives from Ethiopia, Kenya, Somalia, Sudan and the Republic of Djibouti, had recommended that sustained

efforts be made, with international co-operation, to interrupt smallpox transmission in the area and that steps be taken to resolve the uncertainty as to whether transmission had been interrupted in the Ogaden. Special measures were proposed to ensure vaccination and control of persons travelling abroad, especially for the pilgrimage to Mecca. WHO had sent a consultant to assist the surveillance system at points of entry to Saudi Arabia.

Cholera would be dealt with under a separate agenda item. However, Dr Taba wished to stress the importance of vigilance and surveillance, in which WHO was ready to help at all times. At a meeting held two weeks previously in Cairo by the health authorities of the Arab countries, with WHO's collaboration, a plan of action on a sound technical basis had been formulated.

With the transfer of much of the responsibility for biomedical research to the Regions and the increased emphasis on technical co-operation with governments in the WHO programme, the Regional Office would become increasingly involved in such research into urgent health problems and the application of the results of that research. Since the first session of the Regional Advisory Committee on Biomedical Research in 1976, two teams of experts had visited various countries to study research resources, and a directory of research institutions had been compiled. Continuing its very constructive work at its second session in March 1977, the Advisory Committee had agreed that priority should continue to be given to research on health services and manpower development. A small scientific group to review project proposals in this subject had met in early August 1977. The Advisory Committee had also endorsed a suggestion that a regional medical library be designated. An agreement which would come into effect on 1 January 1978 had since been signed with the Pahlavi Medical Library of the Imperial Medical Centre of Iran, Teheran, where a MEDLINE terminal was in operation.

The socioeconomic changes in the Region had been accompanied by a surge of hospital construction and modernization in most countries, and WHO had increasingly been called upon for advice. The Regional Director was considering the establishment of a group of experts to advise countries, on request, on the planning, design and construction of hospitals, efficient utilization of hospital services, and, in particular, the place of the hospital in integrated health care.

With the expansion of services, some countries, as was now well known, were spending 30 per cent or more of their national health budgets on drugs. The whole pattern of supply and use of drugs in the Region required urgent review. Studies on drug needs and utilization in primary health care and in hospitals had continued, in order to provide basic data for national drug policies. WHO had maintained its collaboration in applying internationally accepted standards and practices in production and control and in promoting national drug production and supply.

The past year had seen an improvement in the health situation in Lebanon, where WHO had been providing emergency assistance since October 1975. WHO's collaboration was described in Section 12.1 of the Annual Report. Since January 1977 a senior WHO public health administrator had been assigned to Lebanon, as WHO Co-ordinator advising the Government, and other technical advisers had been assigned as required.

Dr Taba noted that from 1 June 1977 responsibility for UNRWA's health services had been transferred from WHO Headquarters to the Regional Office. From 15 September 1977, Ethiopia, at the request of the Government and with the approval of the World

Health Assembly, had transferred to the African Region. On 29 June 1977, the Republic of Djibouti had become independent. The Republic had been invited to send an observer to the present session, and the Regional Director hoped that this country would soon become a full Member of the Organization.

WHO's use of the Arabic language was growing. A consultative group had met in August 1977 to advise on technical publications and translation and on the preparation of English-Arabic and French-Arabic medical dictionaries. The report of this group would be submitted to the Council of Arab Ministers of Health.

The Regional Director thanked all countries concerned for their contributions to the Voluntary Fund for Health Promotion, which were detailed on pages 80-81. He also thanked the Libyan Arab Jamahiriya for its generous donation of $ 250 000, made known since publication of the Report.

It had always been WHO's policy in the Region to keep the Regional Office staff small, so that funds could be spent on country programmes and not on establishment and administration. Long before the Twenty-ninth World Health Assembly adopted resolution WHA29.48 on programme budget policy, the Office had operated with minimum staff. While the Region's programme and budget had grown to eight and a half times its 1957 level, there had, during that twenty-year period, been only a marginal increase in Regional Office staff. In the past five years the number had actually been reduced, and further reductions were planned to the extent possible without impairing efficiency. The reduction in long-term project staff from 150 in 1976 to 120 in 1977 reflected growing national capacity. WHO Representatives were now bearing greater responsibility, and in one country a national had been designated in that capacity.

Dr Taba proposed that, should the Sub-Committee agree, he would follow the pattern now set for the Director-General's Reports on the work of WHO, presenting a short and then a longer report in alternate years. Thus in 1978, when the Regional Committee would have the biennial programme budget for 1980-1981 to examine, he would present a short Annual Report. In 1979, when no budget would be submitted, the Committee would have a longer report before it.

The Regional Director concluded by thanking the Ministers of Health, educational institutions and Governments of the Region for their effective and close collaboration, which had made the year's achievements possible.

In the ensuing discussion, the many representatives who took part expressed their continuing satisfaction at WHO's collaboration in their health programmes.

A recurring theme was the crucial role of the development of appropriate health manpower in tune with the overall needs of the rapidly expanding health services. Optimism was expressed that the Ministerial Consultation on Health Services and Manpower Development, now due to be held in Teheran in early 1978, would help countries to define and train the types and numbers of personnel needed for their health services. It was suggested that WHO should collaborate in the development of curricula for countries with similar health problems. One country had accelerated its health manpower development programme by providing funds-in-trust, to be administered by WHO as part of the regional fellowships programme, to upgrade post-graduate medical education. Continuing education of existing health personnel also received emphasis from several speakers.

A second and related theme stressed by many representatives was the importance of providing accessible basic curative and preventive health services for all, especially in rural areas. Integrated primary health care, including nutrition, maternal and child care and family health, was considered to be vital to social and economic development, though the countries of the Region should produce their own definition of the content of such care. The present shortage of suitably trained workers to complement the work of physicians could also be alleviated by using nurses and other health personnel when they were available.

Representatives also stressed the importance of effective health education of the public and the value of self-reliance, for example in coping with natural and man-made disasters. One representative noted that, while mental health activities could well be integrated into primary health work, care should be taken to ensure adequate training of the staff involved. He suggested that WHO might convene a meeting on the topic. To assist in integrating its health programme into the wider national development programme, one country had established a supreme health council chaired by the Prime Minister, on which various ministries, sectors associated with health, education and community development were represented, supported by a planning unit in the Ministry of Health.

The joint action to control the recent cholera outbreak was mentioned as an example of the close co-operation among countries of the Region in health matters, and further collaboration in such areas as immunization, tuberculosis control and nutrition was suggested. Though noting that improved treatment of infant gastroenteritis was now available, one representative called for better preventive efforts against diarrhoeal diseases as a whole. He proposed that WHO provide a package of environmental health services, including sanitation, rodent control and education in personal hygiene. One country had established diarrhoea clinics through which infections were traced.

Several representatives expressed concern at the rising cost of health care. It was proposed that WHO should carry out studies on increased drug costs and on the economic aspects of health services generally. One speaker suggested that the Organization should convene a meeting on methods of storage for pharmaceuticals. The suggested formation of an expert group to provide guidance on hospital construction and operation was welcomed. The Sub-Committee was informed that Bahrain's training centre for the repair and maintenance of medical equipment was now accepting students, while the regional training centre in Cyprus was expected to open in 1978.

Representatives welcomed the attainment of independence by the Republic of Djibouti. Several speakers referred to the poor health conditions of the Palestinian people and called for action to ensure that they returned to the land that was theirs.

Responding to the discussion, the Regional Director welcomed the strict measures being applied against smallpox as well as all other infectious diseases by Saudi Arabia, where the health authorities made great efforts during the Mecca pilgrimage. He thanked Egypt for its offer of vaccine. WHO consultants had visited a number of countries to advise them on the storage of drugs; he would bear in mind the possibility of a meeting on the subject. He agreed with one representative's comments on the seriousness of the malaria situation. Many countries had active malaria control programmes in which WHO was collaborating, and it was also co-ordinating inter-country

programmes, for example in the Arabian peninsula. As regards training in the repair of medical equipment, to which two representatives had referred, WHO was already helping national centres, while regional training centres were being set up in Baghdad and Cyprus. The possibility of using the Bahrain centre would also be considered.

He had been glad to learn of the extent of the trend in many countries towards improvement in the relevance of training of health personnel to the countries' needs. Such topics as the type and relevance of training and development of curricula adapted to national needs, as well as all aspects of the interrelationship between health services and health manpower development, would certainly be discussed at the forthcoming Ministerial Consultation. The teaching of psychiatry in medical schools, which one representative had mentioned, had been the subject of a WHO seminar a few years earlier whose recommendations were now being actively followed up.

He agreed that a study of the cost-effectiveness of medical care was needed; as the regional programme budget for 1979 showed, an existing post in the Regional Office was to be replaced by a post for a regional health economist.

Drawing attention to the draft resolution on the Annual Report now before the Sub-Committee, the Regional Director explained that operative paragraph 3 was intended to increase the Regional Committee's involvement in WHO's work in the Region, by providing for a small group of two or three experienced representatives of Member Countries to assist him, through active consultation with himself and his senior staff concerned, in programme and policy development.

The resolution was approved as presented.[1]

2. STATEMENTS AND REPORTS BY REPRESENTATIVES AND OBSERVERS OF ORGANIZATIONS AND AGENCIES: Agenda item 6

The observer from the Palestine Liberation Organization (PLO) stated that the people in the occupied Arab territories continued to suffer under the occupying oppressors, who refused to allow an investigation for fear it would reveal the poor health conditions. PLO had set up hospitals in refugee camps, and was active in the campaign against cholera. Maternal and child health care services were provided in all camps, a programme for primary health care workers was being prepared, and a centre for the disabled had been established. To overcome the problems of deprivation, however, the only solution was for the Palestinian people to return to its country, under PLO's leadership.

The representative of the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) drew attention to two important changes since the 1976 session. First, Sir John Rennie had been succeeded as Commissioner-General by Mr Thomas McElhiney. Secondly, WHO's responsibility for the UNRWA health programme had been transferred to the Regional Office; that change was already proving beneficial. The Agency's budgetary situation was now such that it need not contemplate suspending

[1]Resolution EM/RC27A/R.2.

its services altogether. However, if the projected deficit of $ 13 million was not covered, certain services would have to be curtailed. The Agency also had to finance the establishment of a new camp in Lebanon to house displaced refugees; the camp would initially accommodate 8 500 refugees but could be expanded.

By the end of 1976 the delivery of health services to refugees in Lebanon had improved substantially following the cease-fire in October of that year, though most UNRWA-subsidisedhospitals had been damaged or become inaccessible. The Agency was negotiating to enable UNRWA patients to use the Palestine Red Crescent's services. Despite budgetary difficulties, modest improvements had been achieved in the Agency's health services. Host governments had provided valuable diagnostic and treatment facilities, and UNRWA had co-operated with Ministries of Health in epidemiological surveillance, immunization, and improvements in sanitary facilities. Those relationships had been valuable in the recent cholera outbreak. Altogether, the health of the refugees registered with UNRWA had been maintained.

The representative of the International Agency for the Prevention of Blindness and the World Council for the Welfare of the Blind said that the Council's objectives were to rehabilitate the blind and to improve the quality of their life. To tackle the problem, he reiterated an earlier proposal to establish a regional centre for the prevention of blindness. The Minister of Health of Saudi Arabia had invited countries of the Region to discuss the question. The centre's aims would be to establish new eye hospitals, to develop existing facilities, to train staff to provide eye services, and to study the causes of blindness. The proposal had been put before various meetings, and he suggested that a committee be established to study it and draw up a plan of action. He thanked WHO for its efforts in the prevention of blindness.

Following that statement, the Minister of Health of Saudi Arabia expressed support for the establishment of a regional centre for the prevention of blindness and invited the Sub-Committee to designate the proposed committee to study the question. The Regional Director also supported the proposal. He noted that the revision to the programme budget for 1978 and 1979 (document EM/RC27/3) provided for WHO's participation in the establishment of the centre through the provision of technical advice.[1]

The representative of the World Federation for Mental Health said that when he had served as a member of a working group on psychiatry in medical education some years earlier, the obstacles to progress in mental health in the Region had appeared formidable. However, he felt that his previous gloomy view had been mistaken. New activities had begun, including the establishment of psychiatric clinics in rural areas, training at all levels had been intensified, and psychiatric centres were making a scientific contribution. He welcomed the post-graduate psychiatric training programme at Taif, Saudi Arabia, which had been in operation for two years. The Federation was holding its Third Pan Arab Mental Health Congress in Tunisia in 1978. The next World Congress, to be held in conjunction with the International Year of the Child, would be on the theme of preventive mental health for children and the family.

The representative of the International Paediatric Association said that, although the delivery of health care in most of the developing world was grossly inadequate, there were existing systems that might suggest the way of the future. Maternal and child health/family planning programmes could provide practical solutions, though much depended on government commitment to rural health care. Family planning could

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[1]See also Part V, section 4, and resolution EM/RC27A/R.6.

prove more popular if introduced as a means of spacing, and not limiting, births. That could be done most logically by integrating it with child health services based on nutrition and provided close to the home. Much of the work was routine and could be delegated to auxiliary personnel and volunteers. Integrated training of health workers was important. The main messages for these workers were: to encourage prolonged breast feeding; to improve the weaning diet; to feed sick children, who needed calories as well as protein; and to begin immunization early.

The representative of the International Council of Societies of Pathology referred to WHO's active co-operation in cancer research, and particularly the International Histological Classification of Tumours, which was a valuable aid in the teaching of tumour pathology. Pathologists could made an important contribution to many fields of health activity, for example health information development and investigations of the causes of infant mortality. The countries of the Region had many similar health problems, and the collaboration of pathologists could help in the development of WHO's research programme. He therefore suggested that WHO should organize an annual meeting on pathology in the Region, with the technical supervision of the International Council, to enable pathologists to discuss their problems and co-ordinate their scientific activities.

The representative of the International Council on Alcohol and Addictions said that in 1975, in view of the need for further work on the problems of drug dependence, the Council had started a study in co-operation with the Ministry of Health of Kuwait. It had been found that the use of alcohol and dependence-producing drugs was linked to psychiatric problems. The present approach was to help drug dependent persons to get rid of their habit, but other means might be sought. Three further studies were now in progress, one on psychiatric patients, a second on non-psychiatric patients and a third on the abuse of chemical products among students.

The representative of the World Psychiatric Association said that the Association attached great importance to co-operation with WHO and its regional committees and maintained close ties with the Eastern Mediterranean Region. It was sponsoring a symposium on psychotropic substances together with the Egyptian Psychiatric Association in December 1978. He drew attention to the Declaration on ethics in psychiatry adopted by the General Assembly of his Association in Hawaii in August 1977, which he invited representatives to take into account in their national legislation.

The representative of the Permanent Commission and International Association of Occupational Health said that his Organization valued its close co-operation with WHO. Its objectives were to raise the level of education and training in international health and to co-operate with governments to protect workers' health and increase productivity. The Association held an international conference every three years; the next would be in Yugoslavia in 1978. It also had a number of scientific committees which dealt with the health problems associated with particular industries.

The representative of the United Nations Children's Fund (UNICEF) referred to the fundamental importance attached by UNICEF to child health within basic health services in the developing countries. Assistance to maternal and child health, including water supply, accounted for more than half of UNICEF's total assistance, and that emphasis would continue. Community-based primary health care would shortly be reviewed at two regional meetings, an inter-agency consultation and a regional seminar, both to be held in Alexandria. UNICEF considered that primary health care

should form part of a unified national health structure, that community involvement was essential,and that responsibility for the system lay with the national authorities. UNICEF was co-operating with WHO in the context of expanded programmes of immunization in countries of the Region, with emphasis on the strengthening of support and logistic systems and national self-reliance in vaccine production. The two organizations were also active in other measures for the protection of child health, such as environmental sanitation, clean water, better housing and nutrition, and health education.

The representative of the International Union against Tuberculosis said that the Union had member associations in 98 countries and maintained a branch in the Region. It had recently extended its activities to cover all respiratory diseases. It was also able to obtain funds for international co-operation. Some countries of the Region already had national tuberculosis control activities; others, which lacked the resources needed, had been assisted by WHO and the Union. The Union had arranged travelling seminars in several countries of the Region, and a team of experts would shortly visit the Middle East. He stressed that tuberculosis control was not unduly difficult or expensive. All countries could tackle the disease if they had the necessary will and organization. He noted that unlike most of the Region's health services, tuberculosis was not restricted to the urban centres; consequently, tuberculosis control should also be extended to the periphery.

The representative of the World Federation of Haemophilia said that haemophilia was not well known in the Region, though modern methods of diagnosis might reveal more cases. Kuwait had joined the Federation in June 1977, and he hoped that other countries would follow suit. WHO's assistance in a study of haemophilia in the Region would be welcomed.

The representative of the League of Red Cross Societies referred to the League's role in the annual pilgrimage in Saudi Arabia. Each year it appointed physicians in the proportion of one to every 500 pilgrims. Many of the pilgrims were elderly and needed special care. To reduce the danger of communicable diseases, preventive care should begin when the pilgrims first registered, while physicians should follow the communicable disease situation in Saudi Arabia and be at the disposal of that country's health authorities.

The representative of the United Nations Development Programme (UNDP) said that UNDP was one of the many bodies that worked with WHO, which tried to co-ordinate their health activities. UNICEF, UNDP and WHO were holding talks on the Region's needs in water supply and health, and a UNDP team was now visiting Lebanon. UNDP was also co-operating with WHO and the United Nations Environment Programme to combat pollution in the Mediterranean. It would welcome programmes to assist the people of the Region, especially destitute and rural people. He stressed the value of the experience of such countries as China, which was more relevant than the complex methods of developed countries. It could also prove rewarding to investigate traditional medicines and to draw on Arabic medical literature.

PART III

PROGRAMME MATTERS

1. REVISION TO PROGRAMME BUDGET FOR THE EASTERN MEDITERRANEAN REGION FOR THE FINANCIAL YEARS 1978 AND 1979: Agenda item 8 (Document EM/RC27/3)

Introducing document EM/RC27/3, which contained the revision to the Programme Budget for 1978-1979, the Regional Director explained that its main purpose was to present proposals for additional technical co-operation activities in 1978 and 1979, estimated at US $ 663 000 and US $ 940 000 respectively, which were not included in the original budget estimates submitted in 1976 in document EM/RC26/3. The additional funds had become available to the Region as a result of the implementation of World Health Assembly resolution WHA29.48 on programme budget policy. This resolution called for a reorientation of the working of the Organization to ensure that by 1980 allocations of the regular budget reached the level of at least 60 per cent towards technical co-operation and provision of services to governments. The funds which had now been released to the Region resulted from cuts in establishment costs, mainly at Headquarters but also at the Regional Office.

Initially, these additional funds had been placed in the Regional Director's Development Programme and the document showed how it was intended to make the most effective use of them. Only such activities had been included as were considered highly relevant to the needs of the countries of the Region, with particular regard to their developmental nature and their potential for making definite progress towards the resolution of specific health problems.

The Regional Director pointed out that public health research, country health programming, primary health care, health manpower development, the Expanded Programme of Immunization and special regional training in tropical diseases figured high on the list of these programmes. In addition, provision was made for special activities in the fields of prevention of blindness, formulation of national drug policies, and pre-investment studies for basic sanitary services. Also included was a provision for unpredictable health problems such as emergencies or other newly arising situations. The proposals for the promotion and development of public health research had been elaborated by the Scientific Group on Health Services Research, which had met in Alexandria early in 1977.

No revision of detailed country or inter-country programmes included in the programme budget presented in 1976 had been prepared this year, although some minor changes in the programme for 1978-1979 were under review with individual governments. It was fully understood that during the implementation years, programme changes would be made in consultation with individual governments, but these would not materially alter the main thrust of WHO's collaboration in regional health programmes.

The Regional Director drew attention to the revised table in the document, which gave the latest estimates by appropriation section with a revised tentative projection for 1980-81. The new figures took into account the additional technical co-operation activities under the Regional Director's Development Programme for 1978-79 as well as further increases in the regional allocations expected in future years

as further measures were taken to implement resolution WHA29.48. Further reductions in the Regional Office structure were envisaged in 1980-81 to achieve savings for the benefit of technical co-operation activities.

In reply to observations by representatives, Dr Taba clarified the use of the Regional Director's Development Programme. He expected a further increase in the regional allocation as a result of the measures taken by the Director-General to implement resolution WHA29.48 in subsequent years as further cuts were made in establishment costs. He considered that the allocation of $ 100 000 a year for unpredictable health problems was not excessive in the light of past experience when additional requirements had had to be met unexpectedly as a result of epidemics, armed conflicts and natural disasters. He also referred to the present cholera outbreak, emergency assistance to Lebanon, and recent flood and drought disasters in various countries of the Region. He assured the Sub-Committee that the observations of one representative on the regional orientation of the health manpower development programme would be kept in mind as well as the necessity to make training relevant to the needs of the countries.

In reply to a comment that malaria deserved maximum attention in research, the Regional Director referred to the very deep involvement of WHO through its malaria control programme and the considerable amounts allocated for malaria research globally, to which the present proposals in the Regional Director's Development Programme were contributing in a specific field. The Region would take an active part in the global malaria research programme.

A resolution on the revised programme budget for 1978 and 1979 was adopted unanimously.[1]

2. MEDIUM-TERM PROGRAMME FOR HEALTH MANPOWER DEVELOPMENT IN THE EASTERN MEDITERRANEAN REGION: Agenda item 9 (Document EM/RC27/4)

The subject was introduced by Dr A. Robertson, Public Health Administrator (Health Manpower Development), who began by reminding the Sub-Committee that, whereas the programming and budgeting of the Organization had long been carried out on an annual basis and latterly on a biennial one, its general work plans had also been formulated further ahead, in a series of five- or six-year statements of intent. The most recent of these statements, the Sixth General Programme of Work covering a Specific Period, 1978-1983, had been approved by the Twenty-ninth World Health Assembly in May 1976. At the same Assembly, a long-term programme of work in the field of health manpower development, expressed globally, had also been approved.

Whereas these statements had formed very useful guidelines for the Organization itself, and had been of proven value in indicating to Member governments the general direction in which the Organization was moving, they were not strictly speaking, "programmes" as such. Lacking either time or location of programme activities, and containing no expression of intended outcomes, they did not lend themselves to any effective measurement of achievement.

[1]Resolution EM/RC27A/R.4.

It had been in order to provide for such measurement of achievement that the concept of medium-term programming had been introduced by the Executive Board.

A medium-term programme (MTP) was defined as a six-year detailed schedule of activities, developed year by year throughout the period, and aimed at attaining certain specific targets. The implementation of the programme thus became measurable, and the provision of "output indicators", or milestones along the way, helped to demonstrate progress being made towards the eventual targets.

The Twenty-ninth World Health Assembly had noted the concept of medium-term programming with approval, and in an Assembly resolution (WHA29.72) on the subject of health manpower development, had requested the Director-General, inter alia, "to establish a long-term programme of health manpower development ... in all the regions, taking into account specific needs and possibilities of the countries in each region, and on the basis of this long-term programme build medium-term health manpower development programmes with concrete aims and target indices for evaluation of the results attained, these programmes to be discussed at the regional committee meetings in 1977".

Dr Robertson briefly described the intensive work which had gone into the preparation of the draft global MTP in health manpower development for the Eastern Mediterranean Region, which was before the Sub-Committee for consideration, and pointed out that this document was one of six produced from all regions which would subsequently be incorporated in a global programme prepared by WHO Headquarters, in close association with all regions.

In the light of discussions earlier in the present session, he felt that it would not be necessary to refer further to the extent to which health manpower development in the context of health service needs enjoyed the utmost priority in the Organization and its Member Countries. Health manpower development had been the subject of many discussions at this and previous sessions of the Regional Committee; it accounted for a large share of the WHO budget in the Region and a high proportion of the work of WHO staff.

It was pointed out that the document before the Sub-Committee was an initial step, and an initial step only, taken by the Regional Office to express, for the six years ahead, WHO's programme in HMD in the Region in such terms that the Sub-Committee and the Secretariat would both be able, to the extent possible, to see ahead, predict needed activities, monitor them, and evaluate their achievements.

It was pointed out that the MTP was divided into three broad sub-programme areas, each of which was well known to enjoy high priority in all Member Countries.

The sub-programme areas were:

(a) Manpower planning and management to meet health service requirements (including integration of health services and manpower development and development of systems of continuing education);

(b) Promotion of training for all categories of health personnel (including the promotion of health teams for primary health care); and

(c) Educational development and support (including health learning materials, health literature services, resources and personnel).

Although all readily available information - including estimates - had been put to use in the preparation of the programme, bearing in mind the dynamic nature of such a programme, and the fact that it would be subject to continuous assessment and review, certain things were known to be missing. In the first place, the present MTP did not attempt to express in programmatic terms the health manpower development activities of WHO within the individual countries, and, in the second place, it did not cover all of the existing education and training activities which took place within, and under the auspices of, programme areas in the WHO budget other than that of health manpower development itself. The document was essentially a medium-term programme for the health manpower development activities of a regional or inter-country nature, of the WHO Regional Office for the Eastern Mediterranean.

Some of the reasons for the present deficiencies, which would be corrected in the future, were related to the time available for the preparation of the programme, which had been about eight months. This initial experience of MTP, the first being done in the Organization, had clearly indicated that, particularly for very large and complex programme areas such as health manpower development, a much longer lead time was required. It was anticipated that a minimum of perhaps 15-19 months would be necessary in order to prepare an MTP which gave proper consideration to detail, to within-country activities, in consultation with the countries themselves, and to the interrelationships between the area for which the MTP was being prepared and other programme areas.

Following this general introduction, Dr Robertson used sub-programme area A - "Manpower planning and management to meet health service requirements (including integration of health services and manpower development and development of systems of continuing education)" - to illustrate the nature of the MTP process.

Referring to the document in hand, he explained the concept whereby the programming process evolved from introduction, through situational analyses, objective and target setting, to evaluation, repeatedly stressing the essential intended utility of the process as a tool for monitoring and evaluating WHO's activities.

Two particular activities were selected for more in-depth illustration of the process. The first of these was activity A.1.3, "Development of mechanisms for coordination of health services and manpower development". It had been clear in the debates earlier in the session that this subject was of the highest importance to Member Countries. The way in which the MTP set out the proposed mechanism for the six-year follow-through from the planned Ministerial Consultation on Health Services and Manpower Development, due to be held in Iran in early 1978, was explained.

The other example taken for illustrative purposes was Activity A.2.1, "Development of manpower planning methodology". A working group on health manpower planning was intended to be the first next step in the development of health manpower planning capability. In suggesting the proposed sequence of activities, and in referring to the output indicators relating to this activity, Dr Robertson again stressed the vital need for more effective planning and prediction of health manpower needs in the Region. In order to improve WHO's efforts in this subject, it would be essential to relate its activities closely to those of other sectors, and as well, to draw ever more intensively upon the social and behavioural sciences.

In conclusion, Dr Robertson hoped that the proposed MTP process, and the initial document submitted to the Sub-Committee, would have the approval of the members and that they would find it a useful tool wherewith to assess the work of the Organization in this area.

In a lively discussion which followed, all those who participated strongly endorsed the approach which was being taken by the Organization to introduce this new form of programming. A substantial number of points regarding the content of the MTP were alluded to.

One representative drew attention to the need for a constructive pause during which the Organization and its Member Countries jointly took time to study and plan for the future more effectively than had sometimes been the case in the past.

The desirability of the MTP becoming an instrument for continuous assessment was endorsed, as was the need for continuous awareness of the links which existed between all activities of HMD and the wide variety of factors outside the control of those responsible for health services.

Representatives deplored the lamentable fact that those responsible for the education and training of health personnel were, all too often, total strangers to those planning and running the health services. There was considerable criticism of the isolation from health service reality of universities, medical faculties, and others concerned with such education and training.

Medical faculties, in particular, appeared to several delegations to be especially isolated from the reality of the health needs of their countries, and to be primarily concerned, as one representative put it, with the production of "wonderful doctors for other countries".

The need for more intensive and comprehensive follow-up to the initial steps taken by the Organization in MTP was particularly stressed, as was the need for each individual country now to play its part in the development of its own MTP in health manpower development. A suggestion was made during the debate for the creation of some form of consultative mechanism whereby the Regional Director could call on technical expertise, with particular reference to the future programming and evaluation of the integrated approach to health services and manpower development.

In the course of the debate, a contribution was made by Dr T. Fülöp, Director of the Division of Health Manpower Development, WHO Headquarters, who expressed his gratitude at being able to participate in the meeting, and his gratification at the lively and informed nature of the debate. He had been particularly pleased that so much interest had been shown, both in the MTP process, and in the whole approach to the concept of integrated health services and manpower development, a concept to which birth had originally been given in this Region, which had also pioneered in the core activity of teacher training for the health professions.

Dr Fülöp drew attention to the global medium-term programme in health manpower development and gave a description of some of the steps in its building up. He mentioned, as had other speakers, the dangers inherent in an imbalance in the production of health manpower, and laid special stress on the fact that the health manpower development process was concerned with much more than simple "education and training" itself, but embraced all three of the components upon which the present MTP had been constructed.

In several interventions, it was noted that the discussions had again illustrated the importance of the forthcoming Ministerial Consultation on Health Services and Manpower Development.

The Regional Director, in closing the debate on the subject, welcomed the many and positive interventions which had been made, and the whole-hearted support which had been given by all who had spoken, both to the work being done in health manpower development, and to the innovations in the methods and mechanisms of planning.

The draft resolution was adopted with an additional paragraph expressing the satisfaction of the Sub-Committee at the Regional Director's intention to set up a technical advisory committee on health services and manpower development to collaborate with him on programming and evaluation in this field.[1]

PART IV

TECHNICAL DISCUSSIONS

1. HEALTH EDUCATION, WITH SPECIAL REFERENCE TO THE PRIMARY HEALTH CARE APPROACH: Agenda item 10 (Document EM/RC27/Tech.Disc.1)

The Technical Discussions on "Health education with special reference to the primary health care approach" were held on Wednesday, 12 October, under the chairmanship of H.E. Dr Hussein Al Gazairi (Saudi Arabia).

A paper submitted by the Regional Director formed the background to the Discussions, following which the Sub-Committee adopted resolution EM/RC27A/R.8. A summary report of the Technical Discussions appears in Annex IV.

PART V

OTHER MATTERS

1. RESOLUTIONS OF REGIONAL INTEREST ADOPTED BY THE THIRTIETH WORLD HEALTH ASSEMBLY AND BY THE EXECUTIVE BOARD AT ITS FIFTY-NINTH AND SIXTIETH SESSIONS: Agenda item 7 (Document EM/RC27/5)

The Sub-Committee, after reviewing the resolutions presented for its information in document EM/RC27/5, adopted resolution EM/RC27A/R.3, in which it took note of their contents.

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[1] Resolution EM/RC27A/R.5.

2. ARABIC TEXT OF THE WHO CONSTITUTION: Agenda item 11(a)

The item was introduced by the Regional Director, who briefly traced the history of the use of the Arabic language in WHO. As it had not been an official language of WHO when the Organization was founded, the original authentic texts of the Constitution did not include an Arabic text. A provisional translation into Arabic had been prepared in the Regional Office when Arabic became a working language of the Region.

In 1975, in resolution WHA28.34, the World Health Assembly had decided that Arabic should become a working language of the Organization. In consequence, the Arab States had requested the adoption of an authentic text of the Constitution in Arabic. To meet that request an amendment was required to Article 74 of the Constitution, to add the word "Arabic" before "Chinese". The Article would then read: "The Arabic, Chinese, English, French, Russian and Spanish texts of this Constitution shall be regarded as equally authentic". Meanwhile, work on an Arabic translation had advanced, in consultation with Arab governments. A working group of qualified persons from WHO Headquarters, the Regional Office and the United Nations had met in August 1977 to prepare a final Arabic text, which was now before the Sub-Committee for its approval.

Dr Taba also drew attention to the draft resolution before the Sub-Committee. The object of the draft resolution was to invite governments to propose to the Director-General that Article 74 of the Constitution be amended to include Arabic with the other languages, and that the Arabic text now under discussion be adopted by the World Health Assembly as the authentic Arabic version. As indicated in the draft resolution, such proposals should be in the Director-General's hands by 31 October 1977 in order to meet the time limit for adoption by the Thirty-first World Health Assembly in May 1978, in compliance with Article 73 of the Constitution.

After making minor amendments, the Sub-Committee approved the Arabic text of the Constitution submitted to it. It then adopted the resolution (EM/RC27A/R.7), to which the text was annexed.[1]

3. THE CHOLERA SITUATION IN THE EASTERN MEDITERRANEAN REGION: Agenda item 11(b)

A special technical session on this agenda item was held on 11 October 1977 under the chairmanship of Dr Saadoun Al-Tikriti, Director-General of Preventive Medicine, Iraq. Two WHO specialized technical experts on cholera were present.

[1] Following the adoption of the resolution, the Secretariat was informed that the Government of Kuwait had cabled the Director-General to propose the amendment concerned.

The report prepared by the technical session was reviewed by the Sub-Committee at its plenary meeting on 12 October. A revised version of the report, taking into account the statements of representatives, is attached as Annex III.

The two WHO experts spoke on current developments in the field of cholera.

4. ESTABLISHMENT OF A COMMITTEE TO STUDY THE PREVENTION OF BLINDNESS IN THE REGION

In accordance with its earlier discussion of a proposal by the representative of the International Agency for the Prevention of Blindness and World Council for the Prevention of Blindness (See Part II, section 2 of this report),the Sub-Committee adopted resolution EM/RC27A/R.6, in which it decided to establish a committee to study the prevention of blindness in the Region. The following were appointed members of the Committee.

H.E. Dr Abdel Rahman Al Awadi, Minister of Public Health, Kuwait, Chairman

H.E. Dr Hussein Abdul Razzak Al Gazairi, Minister of Health, Saudi Arabia

H.E. Dr Ali M. Fakhro, Minister of Health, Bahrain

H.E. Dr Ibrahim Badran, Minister of Health, Egypt

H.E. Dr S. Sheikholeslamzadeh, Minister of Health and Welfare, Iran

Dr A.H. Taba, Regional Director, representing WHO

Sheikh Abdullah Al Ghanim, representing the International Agency for the Prevention of Blindness.

The terms of reference of the committee were: to formulate its programme of work and draw up a plan of action; to carry out a feasibility study of the proposal to establish a regional centre for the prevention of blindness; and to determine which countries wished to participate in this activity and to assess their contributions.

5. FORMATION OF AN AD HOC CONSULTATIVE COMMITTEE

Pursuant to operative paragraph 3 of its resolution on the Annual Report of the Regional Director (resolution EM/RC27A/R.2), the Sub-Committee decided to appoint a temporary committee, composed of the Chairman and two Vice-Chairmen of its 1977 session. This temporary committee would be available for consultation with the Regional Director for the planning and drawing up of the terms of reference for the proposed Ad hoc Consultative Committee, the purpose of which was to assist in formulating health policies and setting programme priorities within the WHO regional collaborative programme.

6. ADOPTION OF THE REPORT: Agenda item 12

The Report was adopted by the Sub-Committee as presented.[1]

7. CLOSURE OF THE SESSION: Agenda item 12

Appreciation was expressed to the Regional Director for the excellent organization of the Session. A resolution was adopted thanking H.H. the Emir of Kuwait and his Government, particularly H.E. Dr Abdul Rahman Al Awadi, the Minister of Public Health, for the generous hospitality and facilities afforded to the meeting.[2]

[1] Resolution EM/RC27A/R.9.

[2] Resolution EM/RC27A/R.10.

PART VI

RESOLUTIONS

The resolutions adopted by the Sub-Committee in the course of the session (resolutions EM/RC27A/R.1 - R.10) were as follows:

EM/RC27A/R.1 ADOPTION OF THE AGENDA

The Sub-Committee,

ADOPTS its Agenda as amended.[1]

EM/RC27A/R.2 ANNUAL REPORT OF THE REGIONAL DIRECTOR

The Sub-Committee,

Having reviewed the Annual Report of the Regional Director for the period 1 July 1976 to 30 June 1977;[2]

Noting with satisfaction the progress achieved in most fields of health during the twelve months under review;

Recognizing the need for continued WHO support to countries in strengthening their health services, health manpower development programmes, for the prevention and control of diseases, and for the improvement of their environmental health programmes;

Realizing that the Organization is now deeply involved in intersectoral and inter-agency social and economic development activities in countries of the Region, and that there is a growing tendency among the countries to undertake technical co-operation among themselves by establishing mutual supporting relationships between Member States, with WHO collaboration;

Reaffirming WHO's constitutional responsibility as the co-ordinating authority for international health, and supporting the collaborative role of the Organization,

1. WELCOMES the role played by the Regional Office in promoting technical collaboration between the countries of the Region and with other bilateral agencies;

2. URGES Member States which are able to do so to continue their financial contributions through the Voluntary Fund for Health Promotion, to the benefit of the regional programme;

[1]Document EM/RC27A/1 Rev.1.

[2]Document EM/RC27/2.

3. DECIDES to appoint a small consultative Ad Hoc Committee from amongst representatives of Member States of the Region to collaborate with the Regional Director in formulating health policies and setting programme priorities within the WHO regional collaborative programme;

4. COMMENDS the Regional Director on his report on the work accomplished during the period;

✓ 5. AGREES with the proposed biennial reporting pattern for future reporting to the Regional Committee.

EM/RC27A/R.3 — RESOLUTIONS OF REGIONAL INTEREST ADOPTED BY THE THIRTIETH WORLD HEALTH ASSEMBLY AND BY THE EXECUTIVE BOARD AT ITS FIFTY-NINTH AND SIXTIETH SESSIONS

The Sub-Committee,

Having reviewed the document submitted by the Regional Director drawing attention to resolutions of regional and general interest adopted by the Thirtieth World Health Assembly and by the Executive Board at its fifty-ninth and sixtieth sessions,[1]

TAKES NOTE of the content of these resolutions.[2]

EM/RC27A/R.4 — REVISION TO PROGRAMME BUDGET FOR THE FINANCIAL YEARS 1978 AND 1979

The Sub-Committee,

Having examined and considered the revision to the programme budget submitted by the Regional Director for the years 1978 and 1979 and the revised tentative projections for the years 1980 and 1981;[3]

Realizing that this revision to the programme budget reflects the allocation of funds released from Headquarters to the Eastern Mediterranean Region resulting from progress in the successful implementation of resolution WHA29.48 of the Twenty-ninth World Health Assembly calling for regular programme budget resources allocated to technical co-operation to reach a proportionate level of at least 60 per cent by 1980;

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[1] Document EM/RC27/5.

[2]

WHA30.20	EB59.R13	WHA30.17
WHA30.23	EB60.R4	WHA30.42
WHA30.26	EB60.R5	WHA30.53
WHA30.27		WHA30.54
WHA30.35		EB59.R12
WHA30.37		EB59.R27
WHA30.43		EB59.R28
WHA30.52		

[3] Document EM/RC27/3.

Recognizing that this programme budget revision is restricted to the proposed additional technical co-operation activities planned under the Regional Director's Development Programme for the utilization of these additional funds and reflects no change in detailed country and inter-country programmes included in document EM/RC26/3:

Being fully aware that some minor changes in the programme for 1978 and 1979 have been under review with individual governments, and that during the implementation year further changes in the programme will take place in consultation with the governments concerned, either as a result of cost increases or because of modified requirements and priorities of Member States,

1. NOTES with satisfaction the effective progress accomplished towards the successful implementation of World Health Assembly resolution WHA29.48;

2. FINDS that the additional proposed activities are well planned, comply with the intention and spirit of the Health Assembly's resolution and follow the priorities and general programme of work approved by the Regional Committee and the World Health Assembly;

3. ENDORSES the revision to the programme budget for 1978 and 1979 and the revised tentative projections for 1980 and 1981;

4. REQUESTS the Regional Director to express its recognition and appreciation to the Director-General for his determined efforts towards the successful implementation of Health Assembly resolution WHA29.48.

EM/RC27A/R.5 MEDIUM-TERM PROGRAMME FOR HEALTH MANPOWER DEVELOPMENT IN THE EASTERN MEDITERRANEAN REGION FOR THE PERIOD 1978-1983

The Sub-Committee,

Reiterating the high importance to all Member Countries of the effective preparation, implementation and evaluation of programmes of health manpower development to meet the needs of the countries;

Thanking the Regional Director for his continuous and successful efforts to prepare and implement such programmes in past years; and

Welcoming the efforts now being made to introduce forward programming in such a form that the programme and its constituent activities can be more and more effectively evaluated,

1. NOTES with satisfaction the contents of the draft Medium-Term Programme for Health Manpower Development in the Eastern Mediterranean Region for the period 1978-1983.

2. WELCOMES the Regional Director's intention to set up a technical advisory committee on health services and manpower development to collaborate with him on such programming and evaluation.

EM/RC27A/R.6 ESTABLISHMENT OF A COMMITTEE TO STUDY THE PREVENTION OF BLINDNESS IN THE REGION

The Sub-Committee,

Pursuant to the suggestion made by Sheikh Abdullah Al Ghanim, representative of the International Agency for the Prevention of Blindness and the World Council for the Welfare of the Blind, and Chairman of the Middle East Committee for the Welfare of the Blind, and its Regional Bureau, for setting up a committee including some Ministers of Health from the Region to study promotive measures for the prevention of blindness, including a feasibility study with regard to the establishment of a regional centre,

1. DECIDES that the Committee shall include:

H.E. Dr Abdel-Rahman Al Awadi, Minister of Public Health, Kuwait, Chairman

H.E. Dr Hussein Abdul Razzak Al Gazairi, Minister of Health, Saudi Arabia

H.E. Dr Ali M. Fakhro, Minister of Health, Bahrain

H.E. Dr Ibrahim Badran, Minister of Health, Egypt

H.E. Dr S. Sheikholeslamzadeh, Minister of Health and Welfare, Iran

Dr A.H. Taba, Regional Director, representing WHO

Sheikh Abdullah Al Ghanim, representing the International Agency for the Prevention of Blindness.

2. FURTHER DECIDES that the terms of reference of the Committee shall be:

(a) to formulate a programme of work and to draw a plan of action for the Committee;

(b) to carry out a feasibility study of the proposal to establish a regional centre for the prevention of blindness;

(c) to determine the countries interested in participating in this activity and to assess their contributions.

EM/RC27A/R.7 WHO CONSTITUTION: Authentic Arabic Text and Amendment of Article 74 of the Constitution

The Sub-Committee,

Considering that consequent upon the adoption by the World Health Assembly of resolution WHA28.34 on the use of the Arabic language in the World Health Organization, it would be appropriate that there be an authentic text in Arabic of the Constitution of the World Health Organization in order to give the Arabic language equal status with the other languages in which the Constitution has been drawn up;

Considering that to this end an Arabic text of the Constitution has been prepared and has been considered by the Governments of the Member States in the Region whose language is Arabic,

1. RECOMMENDS to the Governments of the Member States in the Region concerned that pursuant to the provision of Article 73 of the Constitution of the World Health Organization, they should propose to the Director-General that Article 74 be amended by the inclusion before the word "Chinese" of the word "Arabic", the amended text to read in full:

"The Arabic, Chinese, English, French, Russian and Spanish texts of this Constitution shall be regarded as equally authentic";

and that the Arabic text of the Constitution annexed[1] to this Resolution be adopted by the World Health Assembly as the said authentic text.

2. RECALLS that such proposals should be in the hands of the Director-General not later than 31 October 1977, in order to permit him to comply with the provisions of Article 73 of the Constitution.

EM/RC27A/R.8 HEALTH EDUCATION, WITH SPECIAL REFERENCE TO THE PRIMARY HEALTH CARE APPROACH

The Sub-Committee,

Recalling World Health Assembly resolutions WHA28.88 and WHA29.74[2] on 'Promotion of national health services relating to primary health care' and 'Promotion of national health services relating to health technology and rural development' respectively;

Recognizing the physical, social and psychological importance of public involvement and participation in any programme of primary health care;

Considering with interest the working paper submitted by the Regional Director in this respect[3];

Affirming the importance that should be given to the health education aspect of primary health care, both in stimulating public participation and in facilitating the understanding of the technical input,

1. EXPRESSES its conviction that programmes in primary health care will not be successful without adequate health education based on needs and wants of the communities;

2. INVITES Member States to strengthen their health education services in order to meet the requirements of primary health care activities;

[1] See Annex V to this Report.

[2] WHO Handbook of Resolutions and Decisions, Vol.II, 1977, pp.20 and 21.

[3] Document EM/RC27/Tech.Disc.1.

3. RECOMMENDS to the Regional Director that more co-operation be provided to the health education services of Member States to enable them to cope with the emerging challenges of primary health care activities;

4. THANKS the Regional Director for the working paper submitted and for the attention being devoted to this subject in the Region.

EM/RC27A/R.9 ADOPTION OF THE REPORT OF SUB-COMMITTEE A

The Sub-Committee,

1. ADOPTS the report of Sub-Committee A of the Twenty-seventh session of the Regional Committee as presented,[1] with the amendments approved at its last meeting; and

2. REQUESTS the Regional Director to deal with the report in accordance with the Rules of Procedure.

EM/RC27A/R.10 VOTE OF THANKS

The Sub-Committee,

1. EXTENDS to His Royal Highness the Emir of Kuwait its most profound gratitude and warmest thanks for his kind patronage of the session;

2. FURTHER EXTENDS its sincere thanks to the Government of Kuwait and to H.E. Dr Abdel Rahman Al Awadi, Minister of Public Health, for the generous hospitality and facilities afforded to the delegations participating in this session, which greatly contributed to its success.

[1] Document EM/RC27A/3.

ANNEX I

AGENDA

SUB-COMMITTEE A OF THE REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN, 27TH SESSION

1.	Opening of the session	
2.	Election of officers	
3.	Adoption of the agenda	(EM/RC27/1 Rev.1)
4.	Appointment of the Sub-Division on Programme	
5.	Annual Report of the Regional Director to the twenty-seventh session of the Regional Committee	(EM/RC27/2)
	Statements and reports by representatives of Member States	
6.	Co-operation with other organizations and agencies	
	Statements and reports by representatives and observers of organizations and agencies	
7.	Resolutions of regional interest adopted by the Thirtieth World Health Assembly and by the Executive Board at its fifty-ninth and sixtieth sessions	(EM/RC27/5)
8.	Revision to Programme Budget for the Eastern Mediterranean Region for the financial years 1978 and 1979	(EM/RC27/3)
9.	Medium-Term Programme (Health Manpower Development) in the Eastern Mediterranean Region for the period 1978-1983	(EM/RC27/4 and Corr.1)
10.	Technical Discussions: "Health education with special reference to the primary health care approach"	(EM/RC27/Tech.Disc.1)
11.	Other business:	
	(a) Arabic text of the WHO Constitution;	
	(b) The cholera situation in the Eastern Mediterranean Region	
12.	Adoption of the report and closure of the session	

ANNEX II

LIST OF REPRESENTATIVES, ALTERNATES, ADVISERS AND OBSERVERS TO SUB-COMMITTEE A

REPRESENTATIVES OF MEMBER STATES OF THE WHO EASTERN MEDITERRANEAN REGION

AFGHANISTAN

Representative - Dr Rauf Roashan
President Foreign Relations Department
Ministry of Public Health
Kabul

BAHRAIN

Representative - H.E. Dr Ali M. Fakhro
Minister of Health
Ministry of Health
Manama

Alternate - Dr Akbar M. Mohamed
Chairman, Paediatric Department and Deputy Chief of Medical Staff
Manama

Advisers - Dr Fayza Ghabrial
Acting Chief of the Medical Staff of Health Centres
Ministry of Health
Manama

Miss Alice Simaan
Administrative Superintendent
Ministry of Health
Manama

CYPRUS

Representative - Mr Cleanthis Vakis
Director-General
Ministry of Health
Nicosia

DEMOCRATIC YEMEN

Representative - Dr Ahmed Abdulla Basahai
Director, Preventive Medicine
Ministry of Health
Aden

Alternate - Dr Waheeb Abdul Rahim
Vice-Dean of Medical Faculty
Aden University
Aden

EGYPT

Representative - H.E. Dr Ibrahim Badran
Minister of Public Health
Ministry of Public Health
Cairo

Alternate - Dr Mohammed Labib Ibrahim
Under-Secretary of State
in charge of General Administration for Health Foreign Relations
Ministry of Public Health
Cairo

Advisers - Dr Farag Rizk Hassan
Consultant, Ministry of Public Health
Cairo

Dr Ibrahim Bassiouni
Director-General
Foreign Health Relations Department
Ministry of Public Health
Cairo

IRAN

Representative - H.E. Dr S. Sheikholeslamzadeh
Minister of Health and Welfare
Ministry of Health and Welfare
Teheran

Alternate - H.E. Dr Ahmad Diba
Ambassador, Health Adviser
Permanent Delegation of Iran to the United Nations Office at Geneva
Geneva

Advisers - Mr A.N. Amir-Ahmadi
Director-General
International Health Relations Department
Ministry of Health and Welfare
Teheran

Dr Golamali Leyliabadi
Adviser to the Minister
Ministry of Health and Welfare
Teheran

Mr Tofigh Ghafouri
Director-General of Health
Education Unit
Ministry of Health and Welfare
Teheran

IRAQ

Representative - H.E. Dr Riad Ibrahim Husain
Minister of Health
Ministry of Health
Baghdad

Alternate - Dr Saadoun Khalifa Al-Tikriti
Director-General of Preventive Medicine
Ministry of Health
Baghdad

Advisers - Dr Jafar Al Hasani
Director, Health Education
Ministry of Health
Baghdad

Dr Nazar Al Shabander
Chief Medical Officer
Basrah

Dr Abdul Wahab Al Bayati
Chief Medical Officer
Babylon

JORDAN

Representative - Dr Rizk Rashdan
Under-Secretary
Ministry of Health
Amman

KUWAIT

Representative - H.E. Dr Abdul Rahman Al Awadi
Minister of Public Health
Ministry of Public Health
Kuwait

Alternate - Dr Na'el Ahmad Al-Naqeeb
Under-Secretary
Ministry of Health
Kuwait

Advisers - Dr Nouri Al Kazemi
Director, Department of Public Health and Planning
Ministry of Public Health
Kuwait

Dr Sami Matar
Director, Department of External Medical Services
Ministry of Public Health
Kuwait

Dr Khalid Hussein
Director of School Health
Ministry of Public Health
Kuwait

LEBANON

Representative - Dr Robert Saadeh
Director-General of Health
Ministry of Public Health
Beirut

Alternate - Eng. Mahmoud Hallab
Head, Sanitary Engineering Department
Ministry of Public Health
Beirut

LIBYAN ARAB JAMAHIRIYA

Representative - Dr Abdul Majid Abdul Hadi
Under-Secretary
Secretariat of Health
Tripoli

Alternate -	Dr Abdurauf Abu Rkheiss Director of Health Services in Tripoli Secretariat of Health Tripoli
Adviser -	Dr Saleh Azzuz Medical Adviser Permanent Representative of the Secretariat of Health of Libya to the United Nations Office at Geneva Geneva

OMAN

Representative -	H.E. Dr Mubarak Saleh Al Khaduri Minister of Health Ministry of Health Muscat
Alternate -	Dr Abdel Raouf Mohamed Fergany Director of Public Health Ministry of Health Muscat
Adviser -	Mr Sabeil Soleiman Al Jalal Minister's Secretary Ministry of Health Muscat

PAKISTAN

Representative -	Dr Amir Ali Shah Director-General of Health/(ex-officio) Additional Secretary to Government of Pakistan Ministry of Health and Population Planning Islamabad

QATAR

Representative -	H.E. Sayed Khaled Mohamed Al Mana Minister of Public Health Ministry of Public Health Doha
Alternate -	Dr Sayed Ahmed Tajeldin Director, Preventive Health Services Ministry of Public Health Doha

Advisers - Mr Mohamed Ghulum Abou Alfain
Director, Minister's Office
Ministry of Public Health
Doha

Mr Abdul Wahed Al Mawlawi
International Relations Office
Ministry of Public Health
Doha

Dr H.A. Kushkush
Public Health Adviser/WHO Representative
Adviser to H.E. The Minister of
Public Health
Doha

SAUDI ARABIA

Representative - H.E. Dr Hussein Abdul Razzak Al Gazairi
Minister of Health
Ministry of Health
Riyad

Alternate - Dr Hashem Salih El Dabbagh
Director-General of Preventive Medicine
Ministry of Health
Riyad

Advisers - Dr Hassan Baha'ul'din Kremly
Director, International Health Department
Adviser to the Minister
Ministry of Health
Riyad

Dr Samer Saleh Islam
Technical Adviser to the Minister
Ministry of Health
Riyad

Mr Nazmi Hasan Qutub
Secretary for International Conference
Affairs
Office of the Minister
Ministry of Health
Riyad

SOMALIA

Representative - H.E. Col. Musa Rabileh Good
Minister of Health
Ministry of Health
Mogadishu

Alternate - Mrs Edna Adan Ismail
Director, Department of Training
Ministry of Health
Mogadishu

Adviser - Mr Yassin Farah
Head, Foreign Relations Service
Ministry of Health
Mogadishu

SUDAN

Representative - Dr Abbas Mukhtar
Under-Secretary
Ministry of Health
Khartoum

Alternate - Dr Ahmed Ayyoub El Gaddal
Director-General
International Health
Ministry of Health
Khartoum

TUNISIA

Representative - H.E. Mr Mongi Kooli
Minister of Public Health
Ministry of Public Health
Tunis

Alternate - Dr A.R. Farah
Head International Co-operation Division
Ministry of Public Health
Tunis

Adviser - Mr Taher Ben Youssef
Attaché de Cabinet
Ministry of Public Health
Tunis

UNITED ARAB EMIRATES

Representative -	Dr Abdul Wahab Al Muhaideb Director of Preventive Medicine Ministry of Health Abu Dhabi
Alternate -	Mr Sultan Al Kharji Medical Area Director Ministry of Health Abu Dhabi

YEMEN ARAB REPUBLIC

Representative -	H.E. Dr Abdul Malik Mohamed Abdullah Minister of Health Ministry of Health Sana'a
Alternate -	Mr Khaled Abdul Rahman Al-Sakkaf Director, International Health Department Ministry of Health Sana'a
Adviser -	Mr Ali Abdel Aziz Al-Hamami Director, Minister's Office Ministry of Health Sana'a

OBSERVER OF PALESTINE LIBERATION ORGANIZATION[1]

Observer -	Dr Abdel Aziz Al Labadi PLO Representative Ghobeiri P.O. Box 101-25 Beirut

REPRESENTATIVES OF UNITED NATIONS BODIES

UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)	Mr Khalil Issa Othman Resident Representative United Nations Development Programme Kuwait

[1] Invited in accordance with resolution WHA27.37.

	Mr A. Urin United Nations Development Programme Kuwait
UNITED NATIONS CHILDREN'S FUND (UNICEF)	Mr Ibrahim Jabr UNICEF Area Programme Officer United Nations Children's Fund Beirut
	Mr Osman Farag UNICEF Regional Planning Officer United Nations Children's Fund Beirut
UNITED NATIONS RELIEF AND WORKS AGENCY FOR PALESTINE REFUGEES (UNRWA)	Dr Jean Puyet Director of Health and WHO Representative UNRWA Amman Jordan

REPRESENTATIVES AND OBSERVERS OF INTER-GOVERNMENTAL, INTERNATIONAL NON-GOVERNMENTAL AND NATIONAL ORGANIZATIONS

LEAGUE OF ARAB STATES	Dr Zaki Ahmed Hamdi Director, Health Department League of Arab States Cairo Egypt	(Representative)
	Dr Ghaith El Zerikly Deputy Director, Health Department League of Arab States Cairo Egypt	(Representative)
ORGANIZATION OF AFRICAN UNITY (OAU)	Dr Rakotoarivelo Senior Health Specialist Organization of African Unity Addis Ababa Ethiopia	(Representative)
INTERNATIONAL COUNCIL ON ALCOHOL AND ADDICTIONS	Dr Adel Demerdash Safat Kuwait	(Representative)
WORLD FEDERATION OF SOCIETIES OF ANAESTHESIOLOGISTS	Professor Mohamed M. Motaweh Head, Anaesthesia Department Sabah Hospital Kuwait	(Representative)

LEAGUE OF RED CROSS SOCIETIES	Dr Ahmed Shawki Al-Fanjari Kuwait Red Crescent Society Kuwait	(Representative)
INTERNATIONAL AGENCY FOR THE PREVENTION OF BLINDNESS (IAPB) WORLD COUNCIL FOR THE WELFARE OF THE BLIND (WCWB)	Sheikh Abdullah Al Ghanim WCWB Vice-President WCWB Middle East Committee Riyad Saudi Arabia	(Representative)
INTERNATIONAL DENTAL FEDERATION	Dr Ahmed Abdul Aziz Al-Jassem Head of Dental Centre Ministry of Public Health Kuwait	(Representative)
WORLD FEDERATION OF HAEMOPHILIA	Dr A.H. Youssef Salmya Kuwait	(Representative)
WORLD FEDERATION FOR MENTAL HEALTH	Dr Tsung-yi Lin President, World Federation for Mental Health Health Sciences Centre Hospital University of British Columbia Vancouver, B.C. Canada	(Representative)
PERMANENT COMMISSION AND INTERNATIONAL ASSOCIATION ON OCCUPATIONAL HEALTH	Professor Mahmoud Ahmed Hassanein Chairman, Department of Preventive and Occupational Medicine University of Cairo Cairo Egypt	(Representative)
INTERNATIONAL PAEDIATRIC ASSOCIATION (IPA)	Professor Yunus Müftü Professor of Paediatrics Haceteppe Children's Medical Centre Haceteppe/Ankara Turkey	(Representative)
INTERNATIONAL COUNCIL OF SOCIETIES OF PATHOLOGY	Dr P. Dabiri Professor of Pathology Shah Abbas Avenue Isfahan Iran	(Representative)
WORLD PSYCHIATRIC ASSOCIATION	Dr Hussein Darwish Head, Psychiatric Department Psychological Medicine Hospital P.O. Box 1077 Kuwait	(Representative)

INTERNATIONAL FEDERATION OF SURGICAL COLLEGES	Dr J.R. McCallum P.O. Box 36667 Raas Post Office Kuwait (Representative)
INTERNATIONAL UNION AGAINST TUBERCULOSIS	Dr Ihsan El Rifai Regional Secretary Middle East Region of the International Union against Tuberculosis Comité syrien de Défense contre la Tuberculose Aleppo Syria (Representative)
SECRETARIAT GENERAL OF HEALTH FOR THE ARAB COUNTRIES OF THE GULF AREA	Dr Samer Saleh Islam Technical Adviser to the Minister of Health of Saudi Arabia Ministry of Health Riyad Saudi Arabia (Observer)
ARAB FUND FOR ECONOMIC AND SOCIAL DEVELOPMENT	Mr Salah Tayyib Arab Fund for Economic and Social Development Kuwait (Observer)
ASSOCIATION OF MEDICAL SCHOOLS OF THE MIDDLE EAST (AMSME)	Dr Daoud S. Ali Secretary Association of Medical Schools of the Middle East P.O. Box 115234 Beirut Lebanon (Observer)

حُـــرِّر بمدينة نيويورك فى هذا اليوم الثانى والعشرين من يوليو/تموز ١٩٤٦ ، فى نسخـــة واحدة باللغات الأسبانية والانجليزية والروسية والصينية والفرنسية ، وتعتبر كل هذه النصـــوص متساوية فى الحجية . وتودع النصوص الأصلية بمحفوظات الأمم المتحدة . ويرسل الأمين العام للأمم المتحدة نسخا معتمدة منها لكل حكومة من الحكومات الممثلة فى المؤتمر .

ذلك الترتيبات الخاصة بعرض الحجج التى تستند اليها مختلف الآراء المتعلقة بالموضوع .

الفصل التاسع عشر - النفاذ

المادة ٧٨

مع مراعاة أحكام الفصل الثالث، يظل توقيع هذا الدستور أو قبوله مفتوحا لجميع الدول .

المادة ٧٩

(أ) للدول أن تصبح أطرافا فى هذا الدستور :

(١) بالتوقيع دون تحفّظ يتعلق بالموافقة ،

(٢) بالتوقيع المشروط بالموافقة، على أن يتبعه القبول ،

(٣) بالقبول .

(ب) يتم القبول بايداع وثيقة رسمية لدى الأمين العام للأمم المتحدة .

المادة ٨٠

يصبح هذا الدستور نافذا حين يبلغ عدد أطرافه ستا وعشرين دولة من أعضاء الأمم المتحدة، طبقا لأحكام المادة ٧٩ .

المادة ٨١

وفقا للمادة ١٠٢ من ميثاق الأمم المتحدة، يقوم الأمين العام للأمم المتحدة بتسجيل هذا الدستور عندما توقعه دولة واحدة دون تحفّظ يتعلق بالموافقة، أو عندما تودع أول وثيقة من وثائق القبول .

المادة ٨٢

يقوم الأمين العام للأمم المتحدة باعلام الدول الأطراف فى هذا الدستور بالتاريخ الذى يصبح فيه نافذا، كما يعلمها بالتواريخ التى تصبح فيها الدول الأخرى أطرافا فى هذا الدستور.

اثباتا لما تقدّم ، قام الممثلون الموقعون أدناه والمفوضون رسميا لهذا الغرض بتوقيع هذا الدستور .

المادة ٧٢

يجوز للمنظمة ،بشرط موافقة جمعية الصحة بأغلبية ثلثي الأصوات ، أن تخلُف أية منظمة أو وكالة دولية أخرى ، تدخل أغراضها وأنشطتها في مجال اختصاص المنظمة ، وذلك في الوظائف والموارد والالتزامات التي قد يعهد بها الى المنظمة باتفاق دولي أو بترتيبات يقبلها الطرفان ، وتتم بين السلطات المختصة في المنظمات المعنية .

الفصل السابع عشر - التعديلات

المادة ٧٣

يبلغ المدير العام الدول الأعضاء بنصوص التعديلات المقترح ادخالها على هذا الدستور قبل أن تبحثها جمعية الصحة بستة شهور على الأقل . وتصبح التعديلات نافذة بالنسبة لجميع الدول الأعضاء عندما تقرّها جمعية الصحة بأغلبية ثلثي الأصوات ، ويقبلها ثلثا الدول الأعضاء طبقا لقواعدها الدستورية

الفصل الثامن عشر - التفسير

المادة ٧٤

نصوص هذا الدستور بالأسبانية والانجليزية والروسية والصينية والفرنسية تعتبر متساوية في الحجية .

المادة ٧٥

أى مسألة أو نزاع بشأن تفسير هذا الدستور أو تطبيقه لا تتم تسويته بالمفاوضة أو بوساطة جمعية الصحة ، يحال الى محكمة العدل الدولية ، طبقا لنظام المحكمة الأساسي ، ما لم تتفق الأطراف المعنية على طريقة أخرى للتسوية .

المادة ٧٦

للمنظمة أن تستفتي محكمة العدل الدولية في أية مسألة قانونية تنشأ في نطاق اختصاص المنظمة ، وذلك بترخيص من الجمعية العامة للأمم المتحدة أو بترخيص يستند الى أى اتفاق بين المنظمة والأمم المتحدة .

المادة ٧٧

للمدير العام أن ينوب عن المنظمة في المثول أمام المحكمة بشأن أية اجراءات تترتب على طلب اصدار فتوى . ويتخذ المدير العام الترتيبات اللازمة لعرض القضية على المحكمة ،بما في

الفصل الخامس عشر - الأهلية القانونية والامتيازات والحصانات

المادة ٦٦

تتمتع المنظمة فى أراضى كل دولة عضو بالأهلية القانونية اللازمة لتحقيق هدفها وممارسة وظائفها .

المادة ٦٧

(أ) تتمتع المنظمة فى أراضى كل دولة عضو بالامتيازات والحصانات اللازمة لتحقيق هدفها وممارسة وظائفها .

(ب) يتمتع كذلك ممثلو الدول الأعضاء ، والأشخاص المعيّنون للعمل فى المجلس، وموظفو المنظمة الفنيون والاداريون ، بالامتيازات والحصانات الضرورية لحرية ممارسة وظائفهم المتعلقة بالمنظمة .

المادة ٦٨

تحدد هذه الأهلية القانونية والامتيازات والحصانات فى اتفاق مستقل تعدّه المنظمة ، بالتشاور مع الأمين العام للأمم المتحدة ، ويعقد بين الدول الأعضاء .

الفصل السادس عشر - العلاقات مع المنظمات الأخرى

المادة ٦٩

تقام علاقة بين المنظمة والأمم المتحدة بوصف المنظمة احدى الوكالات المتخصصة المشار اليها فى المادة ٥٧ من ميثاق الأمم المتحدة ، ويجب أن توافق جمعية الصحة بأغلبية ثلثى الأصوات على الاتفاق أو الاتفاقات التى تقام بمقتضاها العلاقة بين المنظمة والأمم المتحدة .

المادة ٧٠

تقيم المنظمة علاقات فعالة ، وتتعاون تعاونا وثيقا مع ما يُرغب فيه من المنظمات الدولية الحكومية الأخرى . وتُشترط موافقة جمعية الصحة بأغلبية ثلثى الأصوات على أى اتفاق رسمى يعقد مع أى من هذه المنظمات .

المادة ٧١

للمنظمة أن تتخذ ، فى المسائل التى تدخل فى اختصاصها ، الترتيبات المناسبة للتشاور والتعاون مع المنظمات الدولية غير الحكومية ، وبموافقة الحكومة المعنية ، مع المنظمات القومية الحكومية وغير الحكومية .

المادة ٦٠

(أ) تتخذ قرارات جمعية الصحة فى المسائل الهامة بأغلبية ثلثى الأعضاء الحاضرين المشتركين فى التصويت . وتشمل هذه المسائل : اقرار الاتفاقيات أو الاتفاقات ، والموافقة على الاتفاقات التى تدخل المنظمة فى علاقة مع الأمم المتحدة ومع المنظمات والوكالات الدولية الحكومية وفقا للمواد ٦٩ و ٧٠ و ٧٢ ، وتعديلات هذا الدستور .

(ب) القرارات المتعلقة بالمسائل الأخرى ، بما فى ذلك تحديد طوائف اضافية من المسائل التى يتطلب اقرارها أغلبية الثلثين ، تتخذ بأغلبية الدول الأعضاء الحاضرة والمشتركة فى التصويت .

(جـ) يتم التصويت على المسائل المماثلة بالمجلس وبلجان المنظمة وفقا للفقرتين (أ) و (ب) من هذه المادة .

الفصل الرابع عشر - التقارير التى تقدمها الدول

المادة ٦١

تقدم كل دولة عضو سنويا الى المنظمة تقريرا عمّا اتخذته من اجراءات وما حققته من تقدّم فى تحسين صحة شعبها .

المادة ٦٢

تقدم كل دولة عضو سنويا تقريرا عمّا اتخذته من اجراءات فيما يتعلق بالتوصيات التى قدمتها اليها المنظمة ، وفيما يتعلق بالاتفاقيات والاتفاقات والأنظمة .

المادة ٦٣

تبادر كل دولة عضو بابلاغ المنظمة بما ينشر فيها من قوانين وأنظمة وتقارير رسمية واحصائيات هامة تتصل بالصحة .

المادة ٦٤

تقدم كل دولة عضو تقارير احصائية ووبائية على النحو الذى تقرره جمعية الصحة .

المادة ٦٥

ترسل كل دولة عضو - بناء على طلب المجلس - وبقدر الامكان عمليا ، أية معلومات اضافية تتعلق بالصحة .

المادة ٥٤

المنظمة الصحية للبلدان الأمريكية (١) ، التى يمثلها المكتب الصحى للبلدان الأمريكية ، والمؤتمرات الصحية للبلدان الأمريكية ، وسائر المنظمات الصحية الدولية الحكومية الاقليمية ، التى كانت قائمة قبل تاريخ توقيع هذا الدستور ، تندمج فى المنظمة فى الوقت المناسب . ويتم هذا الاندماج فور امكان تحقيقه عمليا ، باجراء مشترك يقوم على قبول متبادل من السلطات المختصة تعبّر عنه المنظمات المعنية .

الفصل الثاني عشر ـ الميزانية والمصروفات

المادة ٥٥

يعدّ المدير العام تقديرات ميزانية المنظمة ويرفعها الى المجلس . وينظر المجلس فى هذه التقديرات ويرفعها الى جمعية الصحة مشفوعة بما قد يراه مناسبا من توصيات .

المادة ٥٦

مع مراعاة أى اتفاق بين المنظمة والأمم المتحدة ، تدرس جمعية الصحة تقديرات الميزانية ، وتعتمدها وتحدد حصص الدول الأعضاء من النفقات ، وفقا لجدول تضعه جمعية الصحة .

المادة ٥٧

يجوز لجمعية الصحة ، أو للمجلس نيابة عنها ، قبول ما يقدّم للمنظمة من هبات ووصايا ، وادارتها ، على أن تكون الشروط المقترنة بهذه الهبات أو الوصايا ممّا يمكن لجمعية الصحة أو للمجلس قبوله وتكون متفقة مع هدف المنظمة وسياساتها .

المادة ٥٨

ينشأ صندوق خاص لمواجهة الطوارئ والأحداث غير المتوقعة ، ويستخدم وفقا لما يراه المجلس.

الفصل الثالث عشر ـ التصويت

المادة ٥٩

لكل دولة عضو صوت واحد فى جمعية الصحة .

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(١) أصبح اسمها "منظمة الصحة للبلدان الأمريكية" بقرار اتخذه المؤتمر الصحى الخامس عشر للبلدان الأمريكية ، سبتمبر/أيلول ـ اكتوبر/ تشرين الأول ١٩٥٨ .

المادة ٤٩

تضع اللجان الاقليمية نظامها الداخلي .

المادة ٥٠

وظائف اللجنة الاقليمية هي :

(أ) وضع السياسات المتعلقة بالمسائل ذات الطابع الاقليمي الخالص ،

(ب) الاشراف على أنشطة المكتب الاقليمي ،

(جـ) الاقتراح على المكتب الاقليمي أن يدعو الى عقد مؤتمرات فنية ، والقيام بالأعمال الاضافية أو الاستقصاءات المتعلقة بالشؤون الصحية التي ترى اللجنة الاقليمية أنها تعزز هدف المنظمة في الاقليم ،

(د) التعاون مع اللجان الاقليمية المناظرة للأمم المتحدة ، ومع اللجان الاقليمية للوكالات المتخصصة الأخرى ، ومع غيرها من المنظمات الاقليمية الدولية ، التي لها مجالات اهتمام مشتركة مع المنظمة ،

(هـ) تقديم المشورة الى المنظمة ، عن طريق المدير العام ، في الشؤون الصحية الدولية التي تتجاوز أهميتها النطاق الاقليمي ،

(و) التوصية بأن ترصد حكومات الأقاليم المعنية اعتمادات اضافية للاقليم ، اذا كانت حصة الاقليم من الميزانية المركزية للمنظمة لا تكفي للقيام بالوظائف الاقليمية ،

(ز) أية وظائف أخرى قد تفوض الى اللجنة الاقليمية من قبل جمعية الصحة أو المجلس أو المدير العام .

المادة ٥١

المكتب الاقليمي هو الجهاز الاداري للّجنة الاقليمية ، وهو يخضع للسلطة العامة للمدير العام للمنظمة . ويتولى المكتب الاقليمي ، بالاضافة الى ذلك ، تنفيذ قرارات جمعية الصحة والمجلس في الاقليم .

المادة ٥٢

رئيس المكتب الاقليمي هو المدير الاقليمي الذى يعيّنه المجلس بالاتفاق مع اللجنة الاقليمية .

المادة ٥٣

يعيّن موظفو المكتب الاقليمي على نحو يحدد بالاتفاق بين المدير العام والمدير الاقليمي .

المادة ٤٢

للمجلس أن يتخذ الاجراءات لتمثيل المنظمة فى المؤتمرات التى يعتبر أنها جديرة باهتمام المنظمة .

الفصل العاشر - المقر الرئيسي

المادة ٤٣

تحدد جمعية الصحة المكان الذى يكون فيه المقر الرئيسى للمنظمة ، بعد التشاور مع الأمم المتحدة .

الفصل الحادى عشر - التنظيمات الاقليمية

المادة ٤٤

(أ) تحدد جمعية الصحة ، من آن لآخر ، المناطق الجغرافية التى يستحسن انشاء منظمة اقليمية فيها ،

(ب) يجوز لجمعية الصحة ، بموافقة أغلبية الدول الأعضاء التى تقع فى كل منطقة تحدد على هذا النحو ، أن تنشىء منظمة اقليمية لتلبية الاحتياجات الخاصة بتلك المنطقة . ولا يجوز أن يكون هناك أكثر من منظمة اقليمية واحدة فى كل منطقة .

المادة ٤٥

تكون كل منظمة اقليمية جزءا لا يتجزأ من المنظمة وفقا لهذا الدستور .

المادة ٤٦

تتكون كل منظمة اقليمية من لجنة اقليمية ومكتب اقليمى .

المادة ٤٧

تتألف اللجان الاقليمية من ممثلى الدول الأعضاء والأعضاء المنتسبة فى الاقليم المعنى . وللأقطار ، أو مجموعات الأقطار ، الموجودة فى الاقليم وغير المسؤولة عن مباشرة علاقاتها الدولية ، وليست من الأعضاء المنتسبة ، الحق فى أن تمثّل وأن تشترك فى اللجان الاقليمية . وتحدد جمعية الصحة طبيعة ومدى حقوق والتزامات هذه الأقطار أو مجموعات الأقطار فى اللجان الاقليمية بالتشاور مع الدولة العضو أو السلطة الأخرى المسؤولة عن العلاقات الدولية لهذه الأقطار ومع الدول الأعضاء فى الاقليم .

المادة ٤٨

تجتمع اللجان الاقليمية كلما دعت الضرورة ، وهى تحدد مكان كل اجتماع .

المادة ٣٦

يجب أن تكون شروط خدمة موظفي المنظمة مطابقة قدر الامكان للشروط المعمول بها في المنظمات الأخرى للأمم المتحدة .

المادة ٣٧

لا يجوز للمدير العام أو للموظفين ، في أداء واجباتهم ، أن يلتمسوا أو يتلقوا تعليمات من أية حكومة أو سلطة خارج المنظمة ، وعليهم أن يمتنعوا عن أي عمل قد يسيء الى مركزهم كموظفين دوليين . وتتعهد كل دولة عضو في المنظمة من جانبها باحترام الطابع الدولي الخالص للمدير العام وللموظفين ، وبعدم السعي الى التأثير عليهم .

الفصل الثامن - اللجان

المادة ٣٨

ينشىء المجلس من اللجان ما قد تطلب جمعية الصحة انشاءه ، وله أن ينشىء من تلقاء نفسه أو بناء على اقتراح من المدير العام ، أية لجان أخرى يعتبر انشاؤها مرغوبا فيه لخدمة أي غرض يدخل في اختصاص المنظمة .

المادة ٣٩

يبحث المجلس من آن لآخر ، ومرة في كل سنة على أي حال ، مدى ضرورة الابقاء على كل لجنة .

المادة ٤٠

للمجلس أن يتخذ الاجراءات لانشاء لجان مشتركة أو مختلطة مع المنظمات الأخرى أو لاشراك المنظمة في مثل تلك اللجان ، ولتمثيل المنظمة في اللجان التي تنشئها تلك المنظمات .

الفصل التاسع - المؤتمرات

المادة ٤١

لجمعية الصحة أو للمجلس الدعوة الى عقد مؤتمرات محلية أو عامة أو فنية أو غير ذلك من المؤتمرات ذات الطابع الخاص ، للنظر في أي موضوع يدخل في اختصاص المنظمة ، كما يجوز لكل منهما أن يتخذ الاجراءات لكي تمثل في هذه المؤتمرات المنظمات الدولية وكذلك ، بموافقة الحكومة المعنية ، المنظمات القومية ، حكومية كانت أو غير حكومية . وتقرر جمعية الصحة أو المجلس الطريقة التي يتم بها هذا التمثيل .

المادة ٢٩

يمارس المجلس بالنيابة عن جمعية الصحة بكاملها الصلاحيات التي تفوضها الجمعية اليه .

الفصل السابع - الأمانة العامة

المادة ٣٠

تتألف الأمانة العامة من المدير العام ومن قد تحتاج اليه المنظمة من الموظفين الفنيين والاداريين .

المادة ٣١

تعيّن جمعية الصحة المدير العام بناء على ترشيح من المجلس، وفقا لما قد تحدده من الشروط. والمدير العام ، وهو خاضع لسلطة المجلس، هو المسؤول الفنى والادارى الأعلى للمنظمة .

المادة ٣٢

يكون المدير العام ، بحكم منصبه ، أمينا لجمعية الصحة وللمجلس ولجميع لجان المنظمة وللمؤتمرات التى تدعو المنظمة الى عقدها . وله أن يفوض هذه الوظائف الى غيره .

المادة ٣٣

للمدير العام ، أو لمن يمثله ، أن يضع بالاتفاق مع الدول الأعضاء ، طريقة تتيح له ، فى سبيل تأدية واجباته ، الاتصال المباشر بمختلف دوائرها وخاصة اداراتها الصحية والمنظمات الصحية القومية ، الحكومية وغير الحكومية . وله كذلك أن ينشىء علاقات مباشرة مع المنظمات الدولية التى تدخل أنشطتها فى مجال اختصاص المنظمة . وعليه أن يطلع المكاتب الاقليمية على جميع الشؤون التى تهم مناطقها .

المادة ٣٤

يعدّ المدير العام البيانات المالية للمنظمة وتقديرات ميزانيتها ويعرضها على المجلس .

المادة ٣٥

يعيّن المدير العام موظفى الأمانة العامة وفقا للنظام الاساسى للموظفين ، الذى تضعه جمعية الصحة . ويجب أن يكون الاعتبار الرئيسى فى استخدام الموظفين هو ضمان الحفاظ على أعلى مستوى من الكفاءة والنزاهة وطابع التمثيل الدولى للأمانة العامة . ويجب كذلك أن تراعى أهمية اختيار الموظفين على أوسع أساس جغرافى ممكن .

المادة ٢٥

تُنتخب هذه الدول الأعضاء لمدة ثلاث سنوات ، ويجوز اعادة انتخابها ، على أن يكون من بين الدول الأعضاء الأربع عشرة المنتخبة فى أول دورة من دورات جمعية الصحة تعقد بعد نفاذ التعديل الذى أدخل على هذا الدستور وتمت بمقتضاه زيادة عدد أعضاء المجلس من أربعة وعشرين الى ثلاثين عضوا ، دولتان مدة عضويتهما سنة ودولتان مدة عضويتهما سنتان حسبما يتحدد بالقرعة .

المادة ٢٦

يجتمع المجلس مرتين على الأقل فى السنة وهو يحدد مكان كل اجتماع .

المادة ٢٧

ينتخب المجلس رئيسا له من بين أعضائه ، ويضع المجلس نظامه الداخلى .

المادة ٢٨

وظائف المجلس هى :

(أ) تنفيذ قرارات وسياسات جمعية الصحة ،

(ب) العمل كجهاز تنفيذى لجمعية الصحة ،

(جـ) القيام بأية وظائف أخرى تعهد بها اليه جمعية الصحة ،

(د) تقديم المشورة الى جمعية الصحة فى المسائل التى تحال اليه من قبلها ، وفى المسائل التى يعهد بها الى المنظمة بموجب الاتفاقيات والاتفاقات والأنظمة ،

(هـ) تقديم المشورة أو المقترحات الى جمعية الصحة من تلقاء نفسه ،

(و) اعداد جدول أعمال دورات جمعية الصحة ،

(ز) تقديم برنامج عمل عام لفترة معيّنة الى جمعية الصحة للنظر فيه واقراره ،

(ح) دراسة جميع المسائل التى تدخل فى اختصاصه ،

(ط) القيام ، فى نطاق وظائف المنظمة ومواردها المالية ، باتخاذ تدابير الطوارئ لمواجهة الأحداث التى تقتضى اجراء فوريا .

وللمجلس بصفة خاصة أن يخوّل المدير العام اتخاذ الخطوات اللازمة لمكافحة الأوبئة ، والمشاركة فى تنظيم الغوث الصحى لضحايا الكوارث ، واجراء الدراسات والأبحاث التى يوجه نظر المجلس الى صفتها العاجلة أى من الدول الأعضاء أو المدير العام .

لأى اتفاقية أو اتفاق ، الاجراءات المتعلقة بقبول تلك الاتفاقية أو ذلك الاتفاق . وعلى كل دولة عضو أن تشعر المدير العام بما تتخذه من اجراءات . واذا لم تقبل الدولة العضو الاتفاقية أو الاتفاق خلال المدة المحددة تقدم بيانا بأسباب عدم القبول . وفى حالة القبول ، توافق كل دولة عضو على تقديم تقرير سنوى للمدير العام وفقا للفصل الرابع عشر .

المادة ٢١

لجمعية الصحة سلطة اقرار الأنظمة المتعلقة بما يلى :

(أ) الاشتراطات الصحية واجراءات الحجر الصحى وغيرها من الاجراءات التى يراد بها منع انتشار الأمراض على الصعيد الدولى ،

(ب) التسميات المتعلقة بالأمراض وأسباب الوفاة وممارسات الصحة العامة ،

(ج) المعايير المتعلقة بطرق التشخيص لتطبيقها على الصعيد الدولى ،

(د) المعايير المتعلقة بسلامة ونقاء وفعالية المنتجات البيولوجية (الحياتية) والصيدلية وما يماثلها من منتجات متداولة فى التجارة الدولية ،

(هـ) الاعلان عن المنتجات البيولوجية والصيدلية وما يماثلها من منتجات متداولة فى التجارة الدولية وبيان أوصافها .

المادة ٢٢

الأنظمة التى يتم اقرارها طبقا للمادة ٢١ تعتبر نافذة بالنسبة لجميع الدول الأعضاء بعد تلقّى اشعار بتصديق جمعية الصحة عليها . وتستثنى من ذلك الدول الأعضاء التى قد تبلغ المدير العام برفضها اياها أو بتحفظاتها عليها فى خلال المدة المحددة فى الاشعار .

المادة ٢٣

لجمعية الصحة سلطة تقديم التوصيات الى الدول الأعضاء بشأن أية مسألة تدخل فى اختصاص المنظمة .

الفصل السادس - المجلس التنفيذى

المادة ٢٤

يتألف المجلس من ثلاثين شخصا يعيّنهم مثل هذا العدد من الدول الأعضاء . وتقوم جمعية الصحة ، مع مراعاة التوزيع الجغرافى العادل ، بانتخاب الدول الأعضاء التى لها حق تعيين شخص للعمل فى المجلس . وعلى كل من هذه الدول الأعضاء أن تعيّن للمجلس شخصا مؤهلا فنيا فى ميدان الصحة . ويجوز أن يرافقه بدلاء ومستشارون .

(جـ) تعيين المدير العام ،

(د) النظر فى تقارير وأعمال المجلس والمدير العام ، والموافقة عليها ، واعطاء المجلس تعليمات فيما يتعلق بالأمور التى يمكن أن يكون من المرغوب فيه اتخاذ اجراء بشأنها أو اعداد دراسة أو استقصاء أو تقرير عنها ،

(هـ) انشاء اللجان التى قد تراها ضرورية لأعمال المنظمة ،

(و) الاشراف على السياسات المالية للمنظمة والنظر فى الميزانية واعتمادها ،

(ز) تكليف المجلس والمدير العام بتنبيه الدول الأعضاء والمنظمات الدولية ، الحكومية أو غير الحكومية ، الى أى مسألة تتصل بالصحة وتراها جمعية الصحة جديرة بالاهتمام ،

(ح) دعوة أى منظمة دولية أو قومية ، حكومية أو غير حكومية ، تتولى مسؤوليات ذات صلة بمسؤوليات المنظمة ، الى تعيين ممثلين للاشتراك ، دون حق التصويت ، فى اجتماعات الجمعية أو فى اجتماعات اللجان والمؤتمرات التى تعقد تحت سلطتها ، وذلك بالشروط التى تحددها جمعية الصحة ، غير أن المنظمات القومية لا تدعى الا بموافقة الحكومة المعنية ،

(ط) النظر فيما يصدر عن الجمعية العامة أو المجلس الاقتصادى والاجتماعى أو مجلس الأمن أو مجلس الوصاية للأمم المتحدة من توصيات تتعلق بالصحة ، وموافاة هذه الجهات بتقارير عن الخطوات التى تتخذها المنظمة لتنفيذ تلك التوصيات ،

(ى) تقديم تقارير الى المجلس الاقتصادى والاجتماعى طبقا لأى اتفاق بين المنظمة والأمم المتحدة ،

(ك) تشجيع وتوجيه البحوث فى ميدان الصحة عن طريق الاستعانة بموظفى المنظمة أو انشاء مؤسسات خاصة بها ، أو التعاون مع المؤسسات الرسمية أو غير الرسمية لأى دولة عضو بموافقة حكومتها ،

(ل) انشاء ما قد تعتبره مناسبا من مؤسسات أخرى ،

(م) اتخاذ أى اجراء ملائم آخر للنهوض بهدف المنظمة .

المادة ١٩

لجمعية الصحة سلطة اقرار الاتفاقيات أو الاتفاقات المتعلقة بأية مسألة تدخل فى اختصاص المنظمة . ويتطلب اقرار هذه الاتفاقيات أو الاتفاقات موافقة جمعية الصحة بثلثى الأصوات ، وتصبح نافذة بالنسبة لكل دولة عضو متى قبلتها طبقا لقواعدها الدستورية .

المادة ٢٠

تتعهد كل دولة عضو بأن تتخذ فى خلال ثمانية عشر شهرا من تاريخ اقرار جمعية الصحة

المادة ١١

يمثل كل دولة عضو ما لا يزيد عن ثلاثة مندوبين ، تعيّن الدولة العضو أحدهم رئيسا ، وينبغي اختيار هؤلاء المندوبين من بين أكثر الأشخاص كفاءة بقدرتهم الفنية في ميدان الصحة . ويفضّل أن يكونوا ممثلين للادارة الصحية القومية للدولة العضو .

المادة ١٢

يجوز أن يرافق المندوبين بدلاء ومستشارون .

المادة ١٣

تجتمع جمعية الصحة في دورة سنوية عادية وفي دورات خاصة حسبما تقضي الضرورة . وتعقد الدورات الخاصة بناء على طلب المجلس أو أغلبية الدول الأعضاء .

المادة ١٤

تختار جمعية الصحة في كل دورة سنوية البلد أو الاقليم الذي تعقد فيه دورتها السنوية التالية . ويحدد المجلس بعد ذلك مكان الانعقاد ، كما يحدد مكان انعقاد الدورة الخاصة.

المادة ١٥

يحدد المجلس، بعد التشاور مع الأمين العام للأمم المتحدة ، تاريخ انعقاد كل دورة سنوية أو خاصة .

المادة ١٦

تنتخب جمعية الصحة رئيسها وأعضاء مكتبها الآخرين في بداية كل دورة سنوية ، ويظل هؤلاء في مناصبهم حتى يتم انتخاب من يخلفونهم .

المادة ١٧

تضع جمعية الصحة نظامها الداخلي .

المادة ١٨

وظائف جمعية الصحة هي :

(أ) رسم سياسات المنظمة ،

(ب) تسمية الدول الأعضاء التي لها حق تعيين شخص للعمل في المجلس،

لأحكام الفصل التاسع عشر، ووفقا لقواعدها الدستورية، بشرط أن يتم هذا التوقيع أو القبول قبل انعقاد الدورة الأولى لجمعية الصحة .

المادة ٦

مع عدم الاخلال بشروط أى اتفاق بين الأمم المتحدة والمنظمة، يتم اقراره طبقا للفصل السادس عشر، يجوز للدول التى لا تصبح أعضاء وفق المادتين ٤ و ٥ أن تطلب العضوية، ويقبل طلبها متى وافقت عليه جمعية الصحة بالأغلبية البسيطة .

المادة ٧

فى حالة عدم وفاء احدى الدول الأعضاء بما عليها من التزامات مالية للمنظمة، أو فى غير ذلك من الظروف الاستثنائية، يجوز لجمعية الصحة، بالشروط التى تراها مناسبة، وقف امتيازات التصويت، والخدمات التى يحق للدولة العضو أن تتمتع بها . ولجمعية الصحة سلطة اعادة امتيازات التصويت والخدمات هذه .

المادة ٨

يجوز لجمعية الصحة أن تقبل الأقطار أو مجموعات الأقطار غير المسؤولة عن مباشرة علاقاتها الدولية أعضاء منتسبة، بناء على طلب يقدّم نيابة عن القطر أو مجموعة الأقطار من الدولة العضو أو السلطة الأخرى المسؤولة عن العلاقات الدولية للقطر أو لمجموعة الأقطار . وينبغى أن يكون ممثلو الأعضاء المنتسبة لدى جمعية الصحة مؤهلين بكفاءتهم الفنية فى ميدان الصحة، وأن يكون اختيارهم من بين السكان الأصليين . وتحدد جمعية الصحة طبيعة ومدى حقوق والتزامات الأعضاء المنتسبة .

الفصل الرابع - أجهزة المنظمة

المادة ٩

تقوم بعمل المنظمة :

(أ) جمعية الصحة العالمية (المسمّاة فيما يلى بجمعية الصحة)،

(ب) المجلس التنفيذى (المسمّى فيما يلى بالمجلس)،

(جـ) الأمانة العامة .

الفصل الخامس - جمعية الصحة العالمية

المادة ١٠

تتألف جمعية الصحة من مندوبين يمثلون الدول الأعضاء .

(ل) النهوض بصحة ورعاية الأم والطفل وتعزيز القدرة على العيش بانسجام فى بيئة كلّية متغيرة ،

(م) تشجيع الأنشطة فى ميدان الصحة العقلية ، ولا سيّما ما يتصل منها بانسجام العلاقات الانسانية ،

(ن) تشجيع وتوجيه البحوث فى مجال الصحة ،

(س) العمل على تحسين مستويات التعليم والتدريب فى المهن الصحية والطبية والمهن المرتبطة بها ،

(ع) دراسة التقنيات الادارية والاجتماعية المتصلة بالصحة العامة والرعاية الطبية من الناحيتين الوقائية والعلاجية بما فى ذلك خدمات المستشفيات والضمان الاجتماعى وتقديم تقارير عنها ، وذلك بالتعاون مع الوكالات الأخرى عند الاقتضاء ،

(ف) تقديم المعلومات والمشورة والمساعدة فى حقل الصحة ،

(ص) المساعدة فى تكوين رأى عام مستنير لدى جميع الشعوب ، فى شؤون الصحة ،

(ق) وضع تسميات دولية للأمراض ولأسباب الوفاة ، ولممارسات الصحة العامة ، ومراجعة هذه التسميات كلما دعت الضرورة ،

(ر) توحيد طرق التشخيص بالقدر اللازم ،

(ش) وضع معايير دولية للمنتجات الغذائية والبيولوجية والصيدلية وما شابهها ، وتقريرها ونشرها ،

(ت) وبصفة عامة ، اتخاذ كل ما يلزم لبلوغ هدف المنظمة .

الفصل الثالث ـ العضوية والعضوية الانتسابية

المادة ٣

عضوية المنظمة مفتوحة لجميع الدول .

المادة ٤

للدول الأعضاء فى الأمم المتحدة أن تصبح أعضاء فى المنظمة بتوقيع هذا الدستور أو بقبوله بأية طريقة أخرى ، وفقا لأحكام الفصل التاسع عشر ووفقا لقواعدها الدستورية .

المادة ٥

للدول التى دعيت حكوماتها الى ايفاد مراقبين الى مؤتمر الصحة الدولى الذى عقد فى نيويورك سنة ١٩٤٦ أن تصبح أعضاء بتوقيع هذا الدستور ، أو بقبوله بأية طريقة أخرى ، ووفقا

الفصل الأول - الهـــدف

المادة ١

هدف منظمة الصحة العالمية (المسمّاة فيما يلي بالمنظمة) هو أن تبلغ جميع الشعوب أرفع مستوى صحي ممكن .

الفصل الثاني - الوظائف

المادة ٢

تمارس المنظمة لتحقيق هدفها الوظائف التالية :

(أ) العمل كسلطة التوجيه والتنسيق في ميدان العمل الصحي الدولي ،

(ب) اقامة تعاون فعال مع الأمم المتحدة والوكالات المتخصصة والادارات الصحية الحكومية والجماعات المهنية وغير ذلك من المنظمات ، حسبما يكون مناسبا ، والحفاظ على هذا التعاون ،

(جـ) مساعدة الحكومات ، بناء على طلبها ، في تعزيز الخدمات الصحية ،

(د) تقديم المساعدة الفنية المناسبة ، وفي حالات الطوارئ ، تقديم العون اللازم بناء على طلب الحكومات أو قبولها ،

(هـ) تقديم ، أو المساعدة في تقديم ، الخدمات والتسهيلات الصحية بناء على طلب الأمم المتحدة لجماعات خاصة ، كشعوب الأقاليم المشمولة بالوصاية ،

(و) انشاء ما قد يلزم من الخدمات الادارية والفنية ، بما في ذلك الخدمات الوبائية والاحصائية ، والحفاظ عليها ،

(ز) تشجيع واستحثاث الجهود الرامية الى استئصال الأمراض الوبائية والمتوطنة وغيرها من الأمراض ،

(ح) التشجيع - بالتعاون مع الوكالات المتخصصة الأخرى عند الاقتضاء - على اتخاذ الاجراءات المناسبة التي تؤدي الى الوقاية من الأضرار الناجمة عن الحوادث ،

(ط) التشجيع - بالتعاون مع الوكالات المتخصصة الأخرى عند الاقتضاء - على تحسين التغذية والاسكان والاصحاح والترفيه والأحوال الاقتصادية وأحوال العمل وغيرها من نواحي صحة البيئة ،

(ى) تشجيع التعاون بين الجماعات العلمية والفنية التي تسهم في النهوض بالصحة ،

(ك) اقتراح الاتفاقيات والاتفاقات والأنظمة ووضع التوصيات حول الشؤون الصحية الدولية ، والقيام بالمهام التي قد تسند بمقتضاها الى المنظمة وتكون متفقة وهدفها ،

دستور منظمة الصحة العالمية (١)

تعلن الدول الأطراف فى هذا الدستور ، طبقا لميثاق الأمم المتحدة ، أن المبادئ التالية أساسية لسعادة جميع الشعوب ولانسجام علاقاتها ولأمنها :

الصحة هى حالة من اكتمال السلامة بدنيا وعقليا واجتماعيا ، لا مجرّد انعدام المرض أو العجز .

التمتع بأعلى مستوى من الصحة يمكن بلوغه هو أحد الحقوق الأساسية لكل انسان ، دون تمييز بسبب العنصر أو الدين أو العقيدة السياسية أو الحالة الاقتصادية أو الاجتماعية .

صحة جميع الشعوب أمر أساسى لبلوغ السلم والأمن ، وهى تعتمد على التعاون الأكمل للأفراد والدول .

ما تحققه أية دولة فى مجال تحسين الصحة وحمايتها أمر له أهميته للجميع .

تفاوت البلدان المختلفة فى تحسين الصحة ومكافحة الأمراض، ولا سيّما الأمراض السارية ، خطر على الجميع .

النشأة الصحية للطفل أمر بالغ الأهمية ، والقدرة على العيش بانسجام فى بيئة كلّية متغيرة أمر جوهرى لهذه النشأة .

اتاحة فوائد العلوم الطبية والنفسية وما يتصل بها من معارف لجميع الشعوب أمر جوهرى لبلوغ أعلى المستويات الصحية .

الرأى العام المستنير ، والتعاون الايجابى من الجمهور ، لهما أهمية قصوى فى تحسين صحة البشر .

الحكومات مسؤولة عن صحة شعوبها ، ولا يمكن الوفاء بهذه المسؤولية الا باتخاذ تدابير صحية واجتماعية كافية .

وان تقبل الأطراف المتعاقدة هذه المبادئ ، وبغية تحقيق التعاون فيما بينها ومع غيرها ، لتحسين وحماية صحة جميع الشعوب ، توافق على هذا الدستور ، وتنشئ بمقتضاه منظمة الصحة العالمية ، وكالة متخصصة ، وفقا لأحكام المادة ٥٧ من ميثاق الأمم المتحدة .

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(١) هذا الدستور أقرّه مؤتمر الصحة الدولى الذى عقد فى نيويورك من ١٩ يونيو / حزيران الى ٢٢ يوليو/تموز ١٩٤٦ ، ووقّعه فى ٢٢ يوليو/تموز ١٩٤٦ ممثلو ٦١ دولة (السجلات الرسمية لمنظمة الصحة العالمية ٢ ، ١٠٠) ، والتعديلات التى أقرّتها جمعيتا الصحة العالمية العشرون والسادسة والعشرون (القراران ج ص ع ٢٠-٣٦ وج ص ع ٢٦-٣٧) أصبحت نافذة فى ٢١ مايو/ أيار ١٩٧٥ و ٣ فبراير/شباط ١٩٧٧ على التوالى ، وهى مدرجة فى هذا النص .

٤- وقد روئى ، فيما يتصل بالاسم العربى للمنظمة ، استخدام الترجمة العربية المتداولة الآن فى الأمم المتحدة والتى تأخذ بها قرارات الأمم المتحدة ووكالاتها المتخصصة وهى (منظمة الصحة العالمية) ، توخيا للتنسيق بين مختلف المنظمات والوكالات التابعة للأمم المتحدة . وسوف يكون فى اقرار ترجمة الدستور رسميا وابلاغه الى الدول الأعضاء رسميا من قبل المنظمة اشعار بأن هذا الاسم (منظمة الصحة العالمية) يحل ، حيثما يرد ، محل الأسماء الأخرى التى تطلق على هذه المنظمة .

توقيعات

الأستاذ الدكتور مصطفى ياسين
السيد الدكتور عبد المنعم محمد على
السيد الأستاذ عدنان يوسف
السيد الدكتور السيد أبو النجا
السيد الأستاذ رفعت لبيب لطفى
السيد الأستاذ ابراهيم زريقات
السيد الدكتور سامى شبر
السيد الأستاذ محمد يعقوب

تحريرا فى ١٩ أغسطس/آب ١٩٧٧

ORGANISATION MONDIALE DE LA SANTÉ

WORLD HEALTH ORGANIZATION

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ

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Ref.:

محضـر اجتمـاع
مجموعة العمل ، لمراجعة النص العربي
لدستـور منظمـة الصحـة العالميـــة
١٥-١٩ أغسطس/آب ١٩٧٧

١- في المدة من ١٥ الى ٢٠ أغسطس/آب ١٩٧٧ اجتمعت في مقر منظمة الصحة العالمية بجنيف مجموعة العمل المكلفة بمراجعة النص العربي لدستور منظمة الصحة العالمية كما أعدّته أمانة المنظمة ، وفي ظل ما توفر من ملاحظات ومقترحات من المكتب الاقليمي لشرق البحر الأبيض المتوسط ومن بعض الدول العربية .

٢- تشكلت مجموعة العمل على النحو التالي :

الأستاذ الدكتور مصطفى ياسين ، عضو معهد القانون الدولي - رئيسا
السيد الدكتور عبد المنعم محمد علي ، رئيس قسم اللغة العربية بمنظمة الصحة العالمية ، جنيف - مقررا
السيد الأستاذ عدنان يوسف ، رئيس دائرة الترجمة العربية بمقر الأمم المتحدة ، نيويورك
السيد الدكتور السيد أبو النجا ، رئيس قسم الترجمة الفورية العربية بالأمم المتحدة ، جنيف
السيد الأستاذ رفعت لبيب لطفي ، المسؤول عن شؤون الاتصال بين دائرة الترجمة العربية بمقر الأمم المتحدة والأونكتاد ، جنيف
السيد الأستاذ ابراهيم زريقات ، قسم اللغة العربية بمنظمة الصحة العالميـة ، جنيف
السيد الدكتور سامي شبر ، الادارة القانونية بمنظمة الصحة العالمية ، جنيف
السيد الأستاذ محمد يعقوب ، قسم اللغة العربية بالمكتب الاقليمي ، الاسكندرية .

٣- بعد تمحيص جميع المواد المتاحة استقر رأي اللجنة على أن الصيغة المرفقة هي أنسب الصيغ وأكثرها مطابقة للنصوص الرسمية الحالية للدستور ، وللتعبيرات المستخدمة في القانون الدولي وفي نطاق الأمم المتحدة .

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The role of audiovisual material was discussed. It was recognized that these materials could be useful aids to facilitate understanding in education, but that they could not take the place of the process of education itself.

At the conclusion of the meeting, the Regional Director welcomed the importance attached by speakers to the topic and expressed his appreciation of the high level of the Discussions. He also referred to WHO's forthcoming activities in public health education in the Region.

A resolution was unanimously approved at the close of the session.[1]

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[1] Resolution EM/RC27A/R.8.

ANNEX IV

SUMMARY REPORT OF THE TECHNICAL DISCUSSIONS

The Technical Discussions took place on Wednesday 12 October 1977 under the Chairmanship of H.E. Dr H.A.R. Al Gazairi, Minister of Health, Saudi Arabia. The meeting had before it a background paper entitled "Health education with particular reference to the primary health care approach".[1]

The paper dealt with the role of health education in primary health care activities, as regards both the participation and involvement of the public and the training of primary health care workers. It emphasized that "involvement" was a psychological process just as it was a physical one, and that in order to bring about a commitment for involvement, realistic and systematic action in health education was essential.

Some sixteen delegations took part in the discussions that followed the presentation of the paper. While agreeing with the premises, speakers made a number of proposals for the improvement of health education services. It was considered that the entire health programme should include a health education component, starting at the planning stage of each health activity.

It was suggested that health education in schools should be given special priority. One of the first steps would be to prepare teachers to face this challenge, because the purpose of health education in schools was not merely the acquisition of knowledge, but its translation into behavioural patterns conducive to health improving status. The view was also expressed that health education was a continuing process that should be carried out throughout the life of each individual. Of particular importance was the education of mothers, who, by correct upbringing, condition their children to acquire healthful habits. Reference was made in this connexion to the role of community leaders, and especially religious leaders. It was felt that religious leaders could have an immense influence on health habits and that this resource had not been tapped adequately in a number of countries of the Region.

Emphasis was placed by two speakers on the need for training in health education of all public health workers, especially those whose functions require direct contact with the public. In this connexion the role of public health nurses and health visitors in health education was particularly stressed.

It was agreed that while health education at the field level must be part of the duties of every public health worker, there was a need for a nucleus of professional health education specialists in each country to assist, guide, collaborate in and coordinate the health education activities of all health workers and to give on-the-job or in-service training in health education to other health workers. The emphasis in such training programmes should be on methods of community organization, group dynamics, techniques for transferring knowledge, and specific problems arising from the society and culture in which the health activity was to be carried out.

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[1]Document EM/RC27/Tech.Disc.1.

Resolution IX - To urge governments, in collaboration with WHO, to incorporate, in their research programmes, research studies designed to contribute to better long-term control of cholera and, in particular, to urge any country discovering a cholera outbreak to seek the co-operation of WHO and other appropriate agencies in carrying out simple practical epidemiological studies to identify the means of transmission of the disease, so that precise control measures may be promptly taken.

Resolution X - To urge all countries to take note of available scientific evidence regarding the potential risks attached to chemoprophylaxis and take all possible steps to ensure that such evidence has been widely recognized by all those concerned.

Resolution II -

1. To stress the importance of environmental sanitation in co-operation with other authorities concerned and request countries of the Region to allocate budgetary funds to achieve this short- and long-term objective, particularly with respect to safe water and solid and liquid wastes disposal.

2. To ensure the sound implementation of the International Health Regulations concerning disinfection of air and naval means of transport and the safe sanitary disposal of their wastes.

Resolution III - To exchange expertise and information regarding diagnosis, treatment and control of communicable diseases by holding scientific meetings and organizing visits for competent officials in countries of the Region.

Resolution IV - To call upon Governments of the Region to extend health assistance to the Palestinian Red Crescent Association, the Lebanese Ministry of Health and the Somali Ministry of Health.

Resolution V - To form a permanent committee for the control of epidemics in countries of the Region, made up of competent experts from these countries.

Resolution VI -

1. In view of the particular circumstances of the Kingdom of Saudi Arabia as regards the mass Islamic Congregation, namely the Mecca Pilgrimage, this country shall have the right to take such measures and set such requirements as it may deem suitable to facilitate the protection of this Congregation from the introduction of communicable diseases and their spread amongst pilgrims and subsequently to other countries. In so doing, Saudi Arabia shall take into consideration the International Health Regulations.

2. It is recommended to Ministries of Health of Islamic countries that pilgrimage medical missions should include specialists in preventive medicine.

3. To request the Islamic countries to give appropriate instructions so that the medical missions accompanying pilgrims should, immediately upon arrival in Saudi Arabia, establish personal contact with the Saudi Arabian authorities in order that they can work jointly in carrying out such measures and requirements as may be deemed necessary.

Resolution VII - To request all countries of the Region, in collaboration with WHO through the appropriate Regional Offices concerned, to co-ordinate their activities in all suitable ways as closely as possible with neighbouring countries outside the Eastern Mediterranean Region.

Resolution VIII - To advise all countries to take into careful consideration the reaction of the press on the occasion of any cholera outbreak and to give special attention, at the earliest stages of any such outbreak, to briefing effectively those responsible for the press and other mass media regarding the disease and its implications, and to bringing them into close consultation, also at the earliest possible stage, as regards the measures being taken to control the outbreak.

(c) (i) No antibiotics shall be administered to arrivals from infected countries (Reservations: Egypt and Libya). Countries having made reservations shall follow up any persons receiving antibiotics for three to five days.

(ii) No antibiotics shall be given to passengers in transit.

Third : Diarrhoeal cases

In order to be able to detect the first cholera case, attention shall be given to diarrhoeal cases and the necessary laboratory diagnostic examinations shall be carried out.

Fourth : Anti-cholera mass vaccination

The meeting decides that no mass cholera vaccination shall be undertaken as a preventive measure against the spread of the disease. However, emphasis shall be given to other preventive measures such as environmental sanitation and health education through the mass media.

Fifth : Preventive measures in respect of foodstuffs carried by arrivals from infected areas

(a) Foodstuffs mechanically processed and packed in airtight containers shall be permitted entry.

(b) Other foodstuffs, including vegetables, fruits, water and non-alcoholic beverages, shall be prohibited.

Sixth : Preventive measures regarding foodstuffs imported unaccompanied from infected areas

1. Mechanically processed foodstuffs packed in airtight containers shall be permissible.

2. Sterilized bottled mineral and gaseous waters shall be permissible, provided they are accompanied by a health certificate issued and endorsed by the Ministry of Health in the country of origin.

3. Non-pasteurized and non-sterilized milk and dairy products shall be prohibited.

4. Salted fish and fresh uncanned shell-fish shall be prohibited.

5. Fresh dates and figs shall be prohibited.

6. Importation of vegetables and fruits shall be permissible. It is recommended to the health authorities to create awareness amongst the population so that they thoroughly wash and clean vegetables and fruits before consumption.

(Reservations : Egypt, Libya, Sudan and Yemen)

EM/RC27A/WP.1 Rev.1
12 October 1977

ORIGINAL: ARABIC

ANNEX III

REPORT OF THE TECHNICAL SESSION ON THE CHOLERA SITUATION IN THE EASTERN MEDITERRANEAN REGION

Designated technical experts of the delegations attending Sub-Committee A's session met on Tuesday, 11 October 1977, under the chairmanship of Dr Saadoun Al-Tikriti, Director-General of the Preventive Medicine Department, Ministry of Health, Iraq, with the assistance of WHO experts.

After discussing the present situation of cholera in the Region and the repercussions thereof on other Regions, the meeting decided to formulate a unified health policy for the Region to curb the present epidemic and to prevent future episodes, through the adoption of the following resolutions.

Resolution I - To lay down a unified regional plan to prevent the spread of cholera in the Eastern Mediterranean Region:

First : Movement of individuals

(a) Immediately upon appearance of a case of cholera in any country in the Region, the country wherein the case appeared or was detected shall take the following measures:

(i) To notify promptly all other countries of the Region as well as the World Health Organization;

(ii) If a case is imported the country from which the case has arrived as well as WHO shall be notified.

(b) If a cholera incident in a neighbouring country from another Region comes to the knowledge of a country in the Region, WHO shall be notified so that it can take the necessary relevant measures.

Second : Preventive measures to be taken as regards arrivals from infected areas:

(a) No international vaccination certificate against cholera shall be required and countries still having reservations thereon are called upon to reconsider their reservations.

(b) It is recommended that all arrivals be provided with a health control card, with instructions to report to any health centre or clinic whenever morbid symptoms in the digestive system, such as vomiting and diarrhoea, are shown. Airlines and travel agents are requested to print such cards and distribute them to travellers from infected countries for completion during the voyage.