EM/RPD/58-E/R

REPORT ON THE

SEVENTEENTH SESSION OF THE EASTERN MEDITERRANEAN ADVISORY COMMITTEE ON HEALTH RESEARCH

Aleppo, Syrian Arab Republic, 10-12 April 1993

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

The Seventeenth Session of the Eastern Mediterranean Advisory Committee on Health Research (EM/ACHR) was held at Shahba'a Al-Cham Hotel, Aleppo, Syrian Arab Republic, from 10 to 12 April 1993.

2. OPENING SESSION

The session was inaugurated by H.E. the Minister of Health, Syrian Arab Republic, Dr Eyad Chatti, who welcomed the members of the EM/ACHR and said that he hoped that the session will not only review the current situation of health research in the Region, but will also discuss its future plans. Economics of health research was an important topic to be addressed and research must be relevant to the needs of the society. He referred to the Second Syrian Scientific Seminar on Research in Health to be held that morning in which a large number of young scientists from Syria will participate. He noted in particular that this seminar has been financed by the pharmaceutical industry in the country and called for funding of health research not only by the Government, but also by the private sector and the community which will benefit from its results. The role of the Government would be to cater for qualifying and training human resources. He wished the participants every success and a pleasant stay in the historic city of Aleppo.

The session was then addressed by Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean Region of WHO. He thanked the Government of the Syrian Arab Republic for hosting the session of the Committee and Dr Eyad Chatti for agreeing to serve as Chairman of the EM/ACHR and welcomed the new members of the ACHR.

Dr Gezairy noted that during the two years, since the last session, the Regional Office has continued to promote research in the Member States and that EMRO has carried out a number of fruitful activities, including meetings to formulate research policies and strategies, training workshops on research methodology and development of research proposals and grants. He referred, in particular, to the 15th and 16th sessions which discussed cooperation between the ministries of health and universities in the field of health systems research (HSR) and stressed that a change of attitude was needed if HSR was to be effective. A meeting between universities and ministries of health took place in 1992 in Cairo, Egypt. He hoped that research activities would encompass more Member States.

He then briefly reviewed the agenda for the session which would include a progress report on health research in the Region and highlights of the meeting of the global ACHR. The following three topics have been selected for discussion from the 12 suggested at the last session of EM/ACHR:

1) Diseases of modern life-styles;
2) Health aspects of human ecology (including health of immigrants, refugees, displaced populations, etc.); and
3) Health of adolescents.

These topics were selected on the ground of increasing morbidity and significance of certain health problems in the Region. In addition,

a report on "Research Development and Research Training on Human Reproduction" and another on the global ACHR's latest session will be presented.

Dr Gezairy, in conclusion, wished the members a very productive meeting and an enjoyable stay in the beautiful city of Aleppo.

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Dr Iradj Fazel and Dr Adnan Abdel Halim Abbas were elected as Vice-Chairmen of the session and Professor Othman Abdel Malek Babiker as Rapporteur.

3. REPORT ON THE PROGRESS OF THE EMR RESEARCH PROGRAMME, MAY 1991 - APRIL 1993

Dr El Sheikh Mahgoub, Regional Adviser, Research Promotion and Development in EMRO, made the presentation.

Dr Mahgoub surveyed the activities of the regional research promotion and development (RPD) programme since the last session of EM/ACHR in April 1991. He stressed that the activities were directed towards furthering HSR in the EMR in accordance with the objectives of the programme and the recommendations of the EM/ACHR. The activities included the following.

3.1 Intercountry Meetings

The fifth Intercountry Meeting of the National Officers Responsible for Health Research was held in Muscat, Oman, September 1991. The main recommendations of this meeting were:

- HSR structures should be established in the Ministries of Health wherever they do not already exist, and strengthened where they already exist.
- Teamwork and multidisciplinary nature of HSR need to be developed.
- A coordinating body for health research should be established in each country.

An intercountry meeting was held in Cairo, Egypt, in June 1992, to discuss cooperation in HSR between universities and ministries of health. Its main recommendations were:

- A partnership should be established between universities, health ministries and the private sector of the community.
- A sustainable organizational structure is needed to achieve optimal intersectoral coordination, i.e. the establishment of a multisectoral health research council (body).
- Use of national languages is to be encouraged in teaching and implementation of HSR.

An intercountry workshop on HSR at the provincial and district

levels was held in Damascus, Syrian Arab Republic, 27-29 October 1992. Its main recommendations were:

- Decentralization of the research process and development of mechanisms should be encouraged in order to promote peripheral HSR;
- Development of appropriate training schemes for this purpose.
- Promotion of HSR as an integral component in decision-making in regional or local planning.
- Development of focal mechanisms with strong leadership for HSR.

3.2 Visits of the Task Force on Health Research

Visits were undertaken to Morocco and Tunisia by the Task Force on Health Research (to be presented as a separate item).

3.3 Participation in Research Meetings

On behalf of EMRO, the Regional Adviser, Research Promotion and Development, EMRO, participated in five research meetings and workshops in 1991 and eight meetings in 1992 that were concerned with the promotion of research activities and development of research proposals.

3.4 Research Grants and Research Training Grants

In order to stimulate research activity, various innovative methods were tried to increase research activity and research projects, such as the use of consultants or development of proposals during intercountry meetings. During this period, 25 research grants amounting to US$307 840 were supported (5 biomedical; 6 field; 9 HSR; 5 Nutrition). It was gratifying to note the increasing trend towards HSR.

3.5 Research Promotion and Development Activities in Countries

The two RPD/HSR programmes in the EMR countries provide support to national workshops, training courses, recruitment of consultants, fellowships in research management and methodology, etc.

Trainers from three countries in the EMR will participate in the Interregional Workshop on Training of Trainers in HSR (to be held in June 1993).

3.6 Research Activities in Other Programmes

A number of regional programmes, other than RPD, held meetings or workshops in order to further the cause of research. This underlines the increased interest in health research in EMRO.

3.7 Follow-up Actions on the Recommendations on Topics Discussed at the Sixteenth Session of EM/ACHR

3.7.1 Environmental health

The recommendations on environment and health were carried out by

the Centre for Environmental Health Activities (CEHA) in Amman, Jordan.

3.7.2 Health economics

Several training and research activities were carried out in the field of health economics by the Managerial Process for National Health Development (MPN) Unit in EMRO.

3.7.3 Accident prevention

Several Member States have initiated surveys/studies of various types of accidents, particularly road traffic and home accidents, and some have taken steps towards prevention of the road traffic accidents.

3.8 EMRO/Tropical Disease Research/Control of Tropical Disease (EMRO/TDR/CTD) Research Grant

This innovative joint programme provides small grants for control-oriented research, i.e. research of an operative nature, up to US$ 100,000. Out of a total of 31 research proposals, five were supported as presented, and four were further developed and then supported - all on leishmaniasis which was chosen as the first topic. The second topic will be research in schistosomiasis.

Copies of the *EMR Health Services Journal* and the Arabic version of the *Bridge* (the HSR/HQ Journal) were continued to be widely distributed in the Region.

3.9 WHO Collaborating Centres

Seven new WHO collaborating centres were designated in 1992 and five existing ones were redesignated. This indicates the considerable interest shown by Member States in this activity.

4. VISITS OF THE TASK FORCE ON HEALTH RESEARCH TO MOROCCO AND TUNISIA

Professor M. Abdussalam presented this item.

Visits of the Task Force to Morocco and Tunisia from 17 to 28 February 1992 were combined because of the similar situations in health research and other conditions in them. In both countries biomedical research has a long tradition, going back to the early part of this century when Pasteur Institutes were established, in cooperation with the parent Institute in Paris. This tradition of cooperation in biomedical research with institutions in France and other French-speaking countries, such as Belgium, Switzerland and Canada, still continues and plays an important role in research promotion.

The ministries of public health in both countries have realized the necessity of promoting health systems research, especially for developing primary health care services and solving other problems. The Ministry of Public Health (MOPH) in Morocco has designated the National Institute of Health Administration (NIHA) as the focal point for the development of HSR and for training in related methodology. Furthermore, HSR and epidemiological research have been included in the

five-year plans of health development. In addition to HSR carried out by NIHA, the Inspectorate General of Health Services also makes use of HSR to solve some problems in the field.

In Tunisia, the focal point for HSR is the MOPH's Centre for Research and Training in Pedagogy. Some research projects have been carried out in cooperation with WHO. In the field, the Directorate of Primary Health Care and the National Office for Family Planning and Population have been carrying out HSR to evaluate and improve their services and to overcome difficulties in the delivery of health care.

In spite of the action taken by these ministries in both countries to encourage and develop HSR, the bulk of research being carried out, especially in the universities, is clinical and laboratory (biomedical). Such research has a long tradition and some of it is still being carried out in collaboration with institutions abroad, especially in France and other French-speaking countries.

Both HSR and biomedical research show signs of being underfunded. Services to research, especially by library and other information services, are weak. The TF supports the policy and efforts of the MOPH to develop HSR and considers that further development of health research could be greatly augmented by the following measures:

Setting up of a directorate or unit of research in the MOPH in order to develop, encourage and coordinate research in various institutions and to disseminate the results. It should also arrange training in research methodology and establish liaison with national and international agencies in the field of health research. The staff should also carry out HSR.

Further strengthening of the institutions already designated as focal points for HSR.

For effective policy-making, research coordination, allocation of resources, planning and utilization of research, the MOPH would require the advice of a multidisciplinary technical committee on health research, members of which should be drawn from the Ministry, universities, research institutions and other ministries concerned (e.g. planning, agriculture, education).

Provision of a separate budget for supporting research not only in universities and institutions, but also in health services, including at the primary level.

Information services available within the country and abroad (including those from WHO) should be made better known to research workers and institutions.

Training activities, especially in HSR methodology, need to be stepped up at all levels and training materials should be provided in Arabic, using examples of local problems.

WHO's cooperation in all the foregoing measures, especially in training and in strengthening of institutions and provision of documentation, should be enlisted.

Discussion

During discussions of the various topics covered in Sections 3 and 4, the following observations were made:

Various incentives, material or otherwise, were needed for motivating promotion of HSR.

There is a need for more efficient system of information dissemination, including information from WHO to Member States.

Research should move out of institutions to the field and the community.

There is a need for more training in methodologies.

WHO should revise its selection process of participants for its HSR activities, and concentrate on teamwork, rather than on individuals.

Younger scientists should be encouraged, but the older generation should provide example and leadership.

Special Efforts should be made to generate research activity in those countries that lag behind in this respect.

The Task Force should emphasize the multisectoral aspect of HSR and should not concentrate only on the ministries of health.

Preparation of researchers should start right at the medical school - students should be sensitized to HSR and self-learning, and problem-solving approach should be stressed. However, teachers must set an example.

A sense of frustration at the slow progress of HSR was expressed.

In order to give a boost to HSR, there is a need to bring about a change in the whole mental outlook of researchers, and not perform just a patch-up work, to be able to cope with the new economic realities: the problem is not lack of methodology, but lack of proper attitudes on the part of scientists.

Research methodology in the undergraduate curriculum has to be incorporated in the requirements by the General Medical Councils.

Postgraduate curricula must include components of research.

Opinions differed as to whether publication of research should be made mandatory for promotion.

The role of private sector in research funding was stressed.

The available limited resources for research should be spent efficiently and effectively.

The concept of the Basic Minimum Needs approach should be applied to HSR at the community level.

WHO is trying to cover as many areas in health research as possible and has spent significant effort and finances on postgraduate training.

Member States could make use of the Government/WHO Joint Programme Review Missions for securing support for further training in methodologies, etc.

A special section containing bibliography of health services research has been included in the *EMR Health Services Journal*. The topics are currently chosen by the Regional Office, but suggestions were welcome for inclusion of other topics.

Dissemination of information supplied by WHO has to be tackled by the countries themselves. (For example over 200 WHO publications have been distributed to 500 libraries in the Islamic Republic of Iran and also computerized for reference.)

The Task Force made it a point to involve all sectors relevant to health research, in addition to the ministries of health, such as universities, research centres, ministries of planning, etc.

Longer duration needs to be allocated at the EM/ACHR sessions for discussion of research strategies, etc.

The lack of information dissemination not only within the countries, but also within WHO itself at headquarters, between headquarters and regions and amongst the regions, has been noted at the global ACHR. Publication of a newsletter has been suggested as a possible remedy.

There are more than 1000 WHO collaborating centres, but a peer review mechanism is lacking. Thus there is more emphasis on quantity than quality. This lacuna needs to be rectified.

5. WHO ADVISORY COMMITTEE ON HEALTH RESEARCH

Professor M. Gabr, Chairman of the WHO Advisory Committee on Health Research, mentioned the highlights of the latest session held in September 1992.

Health research strategy

A clear health research strategy should be articulated by WHO. The global ACHR considered that health research did not receive the necessary priority it deserves both at the government's level and at the WHO level. The ACHR has recommended that the ACsHR should meet annually, both at the global and regional levels.

An expert group is working to update health research strategy. Stress will be on multisectoral research empowerment of the people, ethical issues and equity.

Coordination and harmonization of health research

Harmonization is especially required not only for dissemination of information, but also to make better use of the limited funds

available. Better dissemination of information, cross representation, joint meetings, etc. are needed.

Resources for health research

Health research should receive more commitment. Various suggestions were discussed:

- WHO would earmark 2-10% of its regular budget for research.
- WHO can act as a broker to remotivate the United nations, bilateral agencies and NGOs to support relevant research activities.
- Industry should be persuaded to support health research.

Ethics and health research

WHO would endorse CIOMS guidelines for epidemiological research and research involving human subjects.

Future Activities of ACHR

WHO research activities should give priority to research that will assist developing countries, and to health systems research, and support multisectoral research. Research should always have a futuristic look on evolving problems and scientific advances.

The task force on evolving problems of critical significance should continue its work on the effect of demographic transitions, industrialization, the effect of economic adjustment and the changing character of existing viral and microbial diseases, as well as the changing prevalence of diseases, etc. In this respect, cancer, for example, will be responsible for 54% of all deaths by the year 2015. There will be 300 million new cases with 200 million deaths from cancer, two-thirds of which will be in developing countries. There are 10 million AIDS cases, and additional 20-30 million will be infected by the year 2000, most of whom will be in developing countries.

The Task Force on Impact of Scientific and Technological Advances on Health will match existing problems with existing technologies and assess new and emerging areas in science and technology that will have the potential for future application to solve health problems.

The Task Force on Health development Research will develop new indicators and revise present ones so that indicators will be more qualitative, intersectoral, multidimensional and dynamic. There was a need to involve the community in health research and the role of women was particularly highlighted.

The Sub-committee on Health Capability Strengthening suggested the following criteria as essential features to strengthen research capabilities in developing countries.

- Political commitment,
- Support of necessary infrastructure,
- Development of a critical mass of young scientists,
- Strong leadership, and
- Sustained and diversified resources.

North-South cooperation is needed, specially in those areas of biomedical research that are relevant to developing countries, as well as in certain areas of training.

South-South cooperation in health research and training should be encouraged. The African and East European countries are in greater need to strengthen their research capabilities.

There are at present more than 1000 collaborating research centres around the world, and there is a need to strengthen the review mechanism of these centres in order to improve the quality and may be to reduce the numbers.

In the short discussion that followed, the following comments were made:

Global strategy and prioritization are lacking, for example in the field of environmental health.
Collaborating centres are considered as an honour by the countries and hence there is an element of pressure in addition to scientific merit. Although there is a chance for terminating of cooperation after three years, in practice, it is difficult to do that. This has to be kept in mind and solutions found.
The global ACHR is considering reverting back to the earlier practice of holding annual sessions, instead of every two years, and the reappointment of members for a second term to overcome the negative aspects of frequent changes in membership.

6. DISEASES OF MODERN LIFE-STYLES

This item was presented by Dr A. Alwan.

Available data on the epidemiology and public health aspects of the most common health problems associated with modern life-styles, namely, cardiovascular diseases, hypertension, diabetes and cancer, were reviewed.

With modernization and urbanization of populations in the EMR, people have developed, on a mass scale, eating habits and dietary patterns hitherto unknown to them. These dietary patterns have predisposed the populations to the development of such health problems. The mass habit of smoking and sedentary life-styles are the other two major contributing factors to the epidemiological change in the patterns of diseases.

Despite the scarcity of data, there is now ample evidence to show that diseases of modern life-styles are now emerging as public health problems of major concern and of increasing dimensions in most countries of the Region. Cardiovascular diseases are now the leading causes of death in many Member States. Hypertension affects 10-18% of the adult population in countries where its epidemiology has been studied. Diabetes has recently been reported to occur in 4-5% of the adult population in Egypt, Iraq, Saudi Arabia and Tunisia, and higher figures approaching 10% are reported from Oman.

Intervention against these noncommunicable diseases in the Region is not only needed, but also feasible. The main approach of such intervention is through health promotion, disease prevention and risk-factor reduction.

An integrated programme can be built to prevent and correct behavioural risk factors associated with socioeconomic development, urbanization and modernization.

However, for intervention programmes to be effective, they must be supported by a strong research base. Priority areas for data collection and research activities relevant to noncommunicable diseases include demographic analysis, epidemiological surveillance, health technology and case management. Member countries are invited to review the current situation of these problems in order to seek better data on their prevalence and underlying risk factors, to strengthen health information systems in Ministries of Health and to respond to the critical need for national investment in essential health research to provide the base for health policies.

WHO may provide guidance in this respect, promote intercountry collaboration, coordinate the establishment of a network of institutions and collaborators interested in noncommunicable disease research, strengthen such collaboration to monitor disease trends, and motivate the development of national programmes.

It was suggested that WHO can also provide support in preparing standardized methodologies for use in epidemiological research, particularly on coronary heart disease, hypertension and diabetes. The need to review current national health research policies and national activities relevant to these problems was also emphasized. Political will and commitment to initiate intervention programmes to control diseases of modern life-styles are prerequisites for success of such programmes.

In the ensuing discussion, the following observations were made.

The environmental factors mentioned in the presentation were amenable for prevention.

Some of the genetic factors, such as consanguineous marriages, may also be amenable for prevention through health education.

Sociobehavioural aspects should be addressed, for example, some habits such as diet resulting in obesity are acquired early in life, especially during infancy, and it is much easier to change these habits at this early stage than later in life. Hence there should be coordination between programmes of these noncommunicable diseases and MCH programmes.

There is a need for more research in case management of these diseases, and this is better done by a multidisciplinary team at the PHC level.

Factors influencing noncommunicable diseases in developing countries are the same as in industrialized countries, and hence,

their experience in planning interventions should be made use of. Relevant demographic data and vital statistics are lacking in many countries of the Region. If certification of death is not possible by doctors, then it can be done by PHC workers. Oral autopsy is best done soon after death and female health visitors may be more appropriate to undertake this mission.

In view of the cost of drugs, emphasis should be on non-pharmaceutical means of controlling hypertension, including change of life-styles which may be more successfully achieved at collective rather than individual level. WHO could well help in this collective health education.

Current policies in the Region, such as on health education, have to be reviewed in the light of the linkage between the findings of the study and the current policy situation.

A programme parallel to EPI, as suggested by the study, should be established.

Only a small proportion of the population of the Region is afflicted with these noncommunicable diseases, as compared to the prevalence of communicable diseases.

The data in the study appear to be hospital-based and hence may not be representative. They differ from some other countries of the Region not included in the study, such as the Islamic Republic of Iran. Data available in countries of the Region, e.g. in local journals and reports, should be acquired and indexed by EMRO.

Statistics may be misleading, e.g. the term "heart failure" may be indicative of a spectrum of diseases not necessarily the ones used in the study.

Emphasis should be on group and cluster studies, rather than on total epidemiological studies which are impossible anyway.

Affliction of this category seem to start with the low socioeconomic groups because the populations in upper strata have access to health education and resources.

The group encompassing hypertension, cardiovascular diseases, diabetes and obesity, could all come under the umbrella of "metabolic syndrome" or "insulin-resistant syndrome", and these could be tackled by concentrating on the public health aspects, rather than clinical ones. A network or a committee needs to be set up to study the problem across the Region.

Stress created by modern life-styles is an important factor to be studied, for example the effects of urbanization. The results of the study should be communicated to policy-makers as solutions will not come from the health sector, but from the socioeconomic system, and hence the required change could be achieved by government action.

Research in this area should be both intra- and inter-sectoral so as to create the necessary environment for change.

The diseases studied may not be commoner today but they are the diseases of the future with the inevitable decline in infectious diseases, undernutrition and childhood diseases.

May be the health administrators have been unable to convince either the politicians or the people; WHO could help by providing convincing proposals. There is scope for standardizing methodology.

Governments might encounter a dilemma when contemplating changes in habits, especially when these may have an adverse economic effect, as happened with tobacco consultation in the U.K., where the increase on taxes on tobacco was more than what was spent on diseases caused by smoking. The participants considered the paper presented as being impressive and comprehensive.

7. HEALTH ASPECTS OF HUMAN ECOLOGY
(including health of immigrants, refugees, displaced populations, etc.)

The item was presented by Ms T. Tuhkanan.

7.1 General

The lack of suitable and well-planned sites and adequate shelters for refugees and displaced persons is quite common. This, together with bad sanitation and inadequate water supply, can adversely affect the well-being of refugees. On the other hand, the overcrowded refugee camps that overuse natural resources can harm their physical environment, and can result in a vicious circle that worsens quickly. The vulnerable population is overloading the carrying capacity and the natural purification potential of its environment.

7.2 Environmental Impact Assessment

Development of refugee camps and settlements includes a broad spectrum of economic, social and environmental activities. The placement of refugees and displaced persons creates a huge demand to provide land, shelter, basic services, facilities and infrastructure. If the basic services and infrastructure development have not kept pace with the increase in the number of refugees, serious environmental and public health problems will arise due to overcrowding, lack of clean water supply, proper sanitation and solid waste management.

Planning

Physical and integrated area and settlement planning is an important tool for achieving an environmentally balanced refugee camp. Sometimes an unplanned and uncontrolled flux of refugees has to be settled without very much preparations, but it is obvious that it can, in the long run, cause environmental and health hazards.

When a camp is established, consideration has to be given to several location factors, such as:

- availability of water
- availability of land

- availability of building material
- occurrence of natural hazards and pests
- climatic factors
- previous settlements
- types of natural vegetation
- land formation and ground conditions
- carrying capacity of the area
- transport facilities
- conflicts with the existing use of the proposed site.

The main activities that have environmental impact are the use of energy and water and production of human and animal waste. The collection of firewood in the surroundings of rural settlements is a major cause of environmental degradation, soil erosion and deforestation. This problem can be solved by providing the refugees with coal or planting community forests for the provision of firewood.

When a virgin land is converted into refugee settlements and people are transferred from one eco-climate zone to a very different one, careful ecological and environmental considerations are needed to avoid adverse health effects, environmental hazards and degradation of nature. The refugees should get training in an ecologically sound way of living, a new way of getting water supply and food, environmental pest control and sanitation, since methods practised previously might not be appropriate under new conditions.

Attention should be paid to the social impact of a refugee camp or settlement on indigenous population and social relationships between the indigenous people and the newcomers. Conflicts can arise from using the same resources, such as water and food, and possible deterioration of environment and possible outbreaks of new diseases.

The availability of local building material is important. Collection or provision of building materials, such as wood, leaves, grass, straw, stone, earth should be so managed that little or no environmental damage takes place. The aesthetic quality and cultural suitability of buildings in a settlement are factors that cause significant social impact. Therefore, a camp and settlement designer should be familiar with the cultural values, living habits and functional requirements of the target populations.

Water supply

A reasonable amount of safe water supply should be arranged so that it covers drinking, cooking, washing and sanitary purposes. The amount of water needed per day per person depends on the temperature and humidity.

For practical reasons, in refugee camps, raw water purification and wastewater treatment can be inadequate. This is why the water source and wastewater must be kept carefully separated. The minimum distance between a water source and wastewater and excreta disposal depends on soil structure, depth of groundwater, slope of land, vegetation, temperature, humidity, rainfall and population density.

Wastewater

The increased amount of water has usually been justified by the expectations of positive impact on health by reducing diseases caused by bacteria, viruses, protozoa and helminths. It may, however, have also adverse effects, if the supply sites are not properly maintained and the wastewater not properly managed.

The main possible impacts of wastewater release on the surroundings are:

- Health hazards due to pathogens and other contaminants
- Health hazards due to increase of disease vectors
- Fish death
- Eutrophication and oxygen depletion of receiving waterbody
- Aesthetic impact (smells, odours).

Kilo 26 in eastern Sudan was one example of a refugee camp established with foreign assistance.

Solutions to environmental health problems in refugee camps

Health education and preparation of teaching material targeted at medical doctors, camp supervisors, health care workers, home visitors and refugees about how to live in a new kind of environment, densely populated, with hazards such as communicable diseases and fire.

Environmental impact assessment of social, economical, environmental health and medical factors as a tool for planning and decision-making.

New guidelines as to how to plan an environmentally safe camp.

Research into priority setting. How to get the best health impact with the resources available?

New appropriate technology for water supply and sanitation.

In the discussion the following comments were made:

The EM Region is perhaps facing the problem of refugees more than any other region of WHO (e.g. Islamic Republic of Iran, Pakistan, Sudan, Cyprus, etc.). Some of the countries of the Region have gained a good experience in managing these problems. The infrastructure and PHC facilities may be limiting factors in coping with these situations.

Refugees bring with them their own diseases, such as malaria. Rapid surveys are needed in these circumstances, for example, nutrition surveillance.

Refugees and displaced around big cities do not remain within their camps, but infiltrate the local population, creating further problems. Social and behavioural problems resulting from this interaction have to be addressed, e.g. sexually transmitted diseases and AIDS.

The role of NGOs and governments in handling refugee problems was discussed. In some countries, for example in the Islamic Republic of Iran, it was mainly the Government; in Cyprus, the NGOs, and in the Sudan a combination of both. Cooperation between the two is required. The use of NGOs from the Region who are morally and culturally more suited to the job would help to avoid problems arising from possible conflicts; EMRO could help to tap this source.

In addition to refugees and "forced immigrants", there is the problem of immigrant workers, the Region being both an importer and exporter of this type of workers. Here two problems arise, one relating to the environment in the country of origin, and the other to the host country environment. There is also the category of tourists, important to economies of some countries of the Region. Though the situation with respect to refugees is well-documented, it is not so with respect to immigrant workers and tourists. There is also the particular issue of refugees under occupation in Palestine.

The recipient countries have to deal not only with the problems of the refugees, but also with the impact they make on the resources available to the local population, often already strained. The local population may resent the newcomers because they may not be getting the same attention.

What are the priorities and programmes of EMRO in this respect especially with regard to HSR? Have any specific research issues been addressed? Have the terms of reference of such studies been defined?

Exchange of information is essential, even European countries (e.g. former Yugoslavia) need to learn from the experience in other parts of the world.

8. HEALTH OF ADOLESCENTS

This item of the agenda was presented by Dr Reyad El Ali of Jordan.

An adolescent has been defined by WHO as being a person between 10-19 years of age. Adolescents encounter many complex changes. Rapid and major developmental adjustments create a variety of stresses, with concomitant problems that have an impact on their health.

What are health problems of adolescents? Violent death and injury, besides problems related to life-styles and behavioural patterns, such as drug abuse and unwanted pregnancies.

The epidemiology of many adult diseases shows evidence that they may have been derived from early abnormal psychological conditions.

Health problems and worries are seen differently by young people as compared with the views of adults, and health planners.

Qualitative research of this kind is quite recent, and is essential for better understanding of youth health needs; therefore, young people are encouraged to participate in the assessment of their health needs.

Youth organizations and NGOs are interested and involved in the health needs of the youth, and their promotion. Young people tend not to use available health services perceiving them as unsympathetic to their needs.

Situation in EMR

The first meeting of the programme, held in Geneva in January 1992, felt that important action was needed to motivate donors, and support country level activities in adolescent health. EMRO encourages countries to designate focal points in ministries of health to facilitate the development of national activities related to the health of adolescents.

EMRO is providing support to, and in some cases sponsoring, country programmes, such as the Tunisian programme for adolescents.

It was hoped that the current session of the ACHR will consider the adolescent health as a major challenge that needs to be tackled by individual, as well as institutional, research focusing on the specific sociocultural aspects and characteristics of young people in the EMR.

In the discussion that followed the presentation, members wondered whether it would be possible to use adolescents as motivators for better health as they were more pragmatic and more science-oriented and whether it was possible to probe into the sexual behaviours of adolescents, given the cultural and religious background with respect to diseases such as AIDS. Though the subject of sex was tackled by Islam in a way that no other religion has done, still the discussion of the subject was a taboo in the Region.

The impact of the mass media, television, on adolescents was discussed, especially violence and sex. It was considered, on the whole, as having adverse effect on this age-group.

There was apparently a communication gap between the elders and adolescents: the latter felt that adults know little about them. Though they can be very effective for health promotion, they are not so with regard to taking care of themselves (for example, careless driving resulting in road accidents).

It was considered that the problems of adolescents can be dealt with through health education at schools in countries where education is widespread. In this regard, the role of the teacher (at school) and of the *imam* in the mosque should be emphasized.

Some participants preferred to solve the problems of adolescents as an integral part of PHC, as has been done in Kuwait, instead of through a seperate programme. The consensus was that sufficient attention was not being given to the problems of adolescents.

9. REPORT ON THE PROGRESS OF THE WHO SPECIAL PROGRAMME FOR RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION

The report was presented by Dr E.O. Akande.

The WHO Special Programme for Research, Development and Research Training in Human Reproduction (HRP) is a global programme of technical cooperation in research in reproductive health, with a broad mandate to coordinate, support, conduct and evaluate research in human reproduction, with particular reference to the needs of developing countries.

HRP conducts research and development of appropriate technologies of high relevance to developing countries and strengthens the material and human Resources for research in developing countries to achieve self-reliance in reproductive health research.

HRP has contributed, through research undertaken by the various multinational and multidisciplinary task forces, to the development and/or improvement of a wide variety of contraceptive methods to suit different needs. It has also developed a standardized protocol for the investigation and clinical management of the infertile couple.

Through the Programme's large-scale studies in different countries, it has been shown that the risk of neoplasia, or of cardiovascular diseases, in contraceptive users living in developing countries does not differ appreciably from that in developed countries.

The establishment and general acceptance, on a truly global basis, of international ethical standards for conduct of clinical research in human reproduction is one of the major achievements of HRP.

In addition, HRP has supported the strengthening of research capabilities of developing countries to enable them to meet their needs for essential national research in reproductive health, as well as participating in the global research effort to generate new technologies and information in the area.

HRP has, in the last two years, continued to strengthen and expand its activities in the Eastern Mediterranean Region. During this period, the Programme has had collaborative activities in five countries: Egypt, Islamic Republic of Iran, Pakistan, Sudan and Tunisia. Centres in these countries have taken part in HRP multicentre studies as well as centre-specific research projects supported by the Programme's Long-term Institutional Development Grants.

A total of US$4 917 505 has been spent in providing support to centres in the Eastern Mediterranean Region since the inception of HRP in 1972. Of this amount, US$553 029 were spent during 1990-1991 biennium in support of 22 research projects and the award of nine grants to institutions in the Region. During this biennium, 14 scientists from the Region acted as members of HRP's scientific committees.

A Regional Needs Assessment Workshop for the Region was held in Cairo, Egypt, in December 1992 and was attended by 24 participants from 11 countries of the Region. The specific objectives of the workshop were to:

- assess the current status of research in reproductive health in countries of the Eastern Mediterranean Region;

- identify specific reproductive health problems in these countries and select priority research areas that are relevant to the identified problems;
- measure the research capabilities of the countries in order to conduct research in the identified areas; and
- assess the resource needs for strengthening research in reproductive health in the countries of EMR.

The workshop addressed safe motherhood, fertility regulation, infertility and sexually transmitted diseases and made valuable recommendations with special reference to priority areas of research in human reproduction in the Region.

Compared to other regions of WHO, collaborative research activities with HRP in the Eastern Mediterranean Region have been rather limited. However, the Programme aims at increasing significantly these collaborative activities based on the recommendations emanating from the Regional Needs Assessment Workshop of December 1992.

In the ensuing discussion, the following comments were made:

Despite the broadening of the mandate of HRP to include all facets of reproductive health, there still appears to be misgivings by some countries in the Region about the Programme's activities due to the prevailing religious and sociocultural climate.

Concern was expressed at the rather limited collaborative activities of HRP in the Region, especially as the Programme is currently working only in five countries in EMR.

HRP research on natural family planning methods (including breast-feeding), infertility and safe motherhood is commendable and should be of interest to EMR.

Further research should be devoted to the special sociocultural (including religious) determinants of reproductive health in the Region.

Every effort should be made to increase the involvement of scientists and institutions of the Region in the activities of HRP.

10. CONCLUSIONS AND RECOMMENDATIONS

10.1 Conclusions

1. The Committee commended the progress of the regional research programme, especially its efforts to promote HSR through advocacy, training programmes, and the support of joint HSR training and activities between academic institutions and the ministries of health. The Committee fully supported the recommendations of both the Meeting of National Officers Responsible for Health Research (Muscat, 9-11 September 1991) and the Intercountry Meeting on Cooperation between Universities and Ministries of Health on Health Systems Research (Cairo, June 1992). The Committee expressed its appreciation on the publication of the *EMR Health Services*

Journal by EMRO as a means for increasing the flow of research information among Member States. It also noted with satisfaction the designation of new collaborating centres and the redesignation of some existing ones in the Region.

Visits by the Task Force to Morocco and Tunisia

2. The usefulness of this approach in assisting countries to formulate their research policies/strategies with emphasis on HSR, as well as the importance of follow-up visits, was reaffirmed.

3. The increase in noncommunicable diseases (such as cardiovascular diseases, cancer, diabetes, etc.) in several countries of the Region was brought to the attention of the Committee. Socioeconomic changes, urbanization and altered life-styles, the main underlying factors, should be taken into consideration to develop effective interventions. Research in this area requires the participation of health and health-related professionals, such as demographers, behavioural scientists, sociologists, anthropologists, etc. Attention should also be given to genetic factors and nutritional behaviours acquired in childhood.

4. Health care of refugees as a result of national or man-made disasters poses a major problem to countries with scarce resources. The suddenness and magnitude of such events require a level of preparedness which does not usually exist in many countries of the Region. Establishment of refugee camps requires a variety of investigations which include natural drainage of selected sites, potential for vegetation, previous habitation, carrying capacity, transportation, availability of building material as well as water and energy sources and facilities for solid and liquid waste disposal. In addition, the possibilities of conflict between the indigenous population and the refugees in the camp should be studied.

   From the health point of view the availability of health care facilities within, or nearer to, the camp site should be ensured; for example, PHC centres which could be manned partly by the refugees themselves. Vaccinations and other preventive interventions should be available and health education activities should be ensured. Availability of acceptable food, as well as special foods for children should be ensured. The management of such camps should make the best use of available resources under the existing circumstances.

5. The importance of health of the adolescents was fully endorsed by the Committee, and the nature of the diseases and injuries as well as the behavioural and attitudinal aspects of this phase of life was highlighted by the Committee. The inadequate research in this area was noted by the Committee, as well as the potential contribution that NGOs can provide in studying the various aspects of adolescent health. The role of school health services as provider of preventive or curative services, as well as their impact on educational achievement was discussed by the members, who endorsed unanimously the need to continue and improve the existing programme in the Region.

6. While the Committee commended the broad coverage of the WHO Special Programme of Research, Development and Research Training in Human Reproduction, specially its work on natural family planning methods, infertility and safe motherhood, it expressed concern on the rather slow growth of collaborative activities in EMR.

10.2 Recommendations

In spite of the progress made in HSR in some of the Member States in the EMR, HSR is far from being institutionalized as an integral component of the managerial process for national health development. While lack of resources is usually blamed, the EM/ACHR members felt that inadequate political commitment, lack of qualified personnel and research capabilities and negative attitudes of the academia are more serious factors. It seems that there is a need to develop appropriate alternative strategies for various situations and to give adequate emphasis to the challenging factors of the process of "institutionalization". Based on the above overall view, the members of the Committee made the following recommendations:

It was recommended that WHO should:

1. continue the promotion of HSR through advocacy and extended training programmes, in cooperation with the health agencies of Member States;

2. continue its efforts to provide health information services to research workers, as well as ensure flow of information between Member States. The *EMR Health Services Journal* was cited as a successful activity;

3. consider holding a joint meeting of specialists in health information and HSR to deal with the abovementioned suggestion;

4. continue efforts to obtain more funds, including those from the private sector, for HSR;

5. continue to assist Member States in the development of national critical mass in HSR;

6. encourage and assist Member States to give more emphasis on developmental health systems research in order to develop more relevant, efficient and effective health interventions.

7. give higher priority to assist research proposals that enhance the development of research teams and develop linkages between ministries of health and universities;

8. encourage countries to develop HSR partnership with NGOs and/or private sector, both in undertaking HSR or augmenting available resources. Such partnership should be designed in a way that does not deprive ministries of health of their research capabilities;

9. develop a more effective mechanism for collection of information generated from HSR studies in the EMR and its diffusion among the Member States of the Region;

10. assist Member States to develop case studies of successful institutionalization of HSR as a managerial tool, to be included in regional and national HSR training activities;

11. continue the initial and follow up visits of the Task Force, preferably after two years, until all Member States are visited;

12. Member States should encourage the use of HSR in policy formulation and evaluation.

13. Countries should encourage HSR in universities and other academic institutions until this form of research is fully recognized as is the case with biomedical research at present.

14. The Committee noted with satisfaction that new collaborating centres have been designated and some of the existing ones redesignated. The services of these centres should be made known widely to research workers and others in order to enable them to use the facilities of these centres.

Diseases of Modern Life-Styles

15. Member States should review the present situation of diseases of modern life-styles and seek better data on the incidence, prevalence and case fatality rates of these diseases, as well as the prevalence of modifiable risk factors.

16. EMRO should encourage and assist Member States to promote research proposals and implement studies for identifying the various determinants (medical, psychological genetic, environmental, behavioural, etc.) of diseases of modern life-styles.

17. Member States should give more emphasis to preventive approaches to avoid the serious consequences of noncommunicable diseases. Such effort should be of multisector in nature, guided by the scientific information generated and communicated by the health sector to all other relevant sectors, as well as risk-groups, both intra- and inter-sectoral.

18. HSR could be used by countries to identify more acceptable and cost-effective approaches and mechanisms to promote healthy behaviour and improve life-styles.

19. A network should be set up to study the problem of noncommunicable diseases across the Region and formulate a regional research programme.

Health care of refugees

20. Member States should encourage and assist in the conduct of environmental impact assessments as a tool for the planning of refugee camps and for prioritization of actions needed and possible remedial efforts. This evaluation should include social, cultural, economical and medical factors, as well as environmental health and technical considerations.

21. WHO should support research on health aspects of migrant groups of economic importance (migrant workers, tourists), and plans made to discuss this issue at a future meeting.

Health of adolescents

22. Member States should be encouraged to identify and assess the actual needs of adolescents, as well as their perception, attitudes and behaviours related to these needs and mechanisms.

23. Alternative approaches and mechanisms to deal with health problems of adolescents should be explored and evaluated.

24. The school health services, because of their importance in the prevention of diseases of the adolescents, seems to be one possible route for the research to reorient these services to the social and behavioural aspects, and should be encouraged in order to improve their impact on the educational process.

WHO Special Programme of Research, Development and Research Training in Human Reproduction

25. More efforts are needed to study sociocultural determinants (including religious) of reproductive health.

26. The Committee, however, expressed concern about the rather limited collaborative activities of the Programme in the EMR, and urged that all concerned should make every effort to increase the involvement of scientists and institutions of the Region in the research activities of HRP.

Annex 1

AGENDA

1. Opening of the meeting
2. Selection of the Vice-Chairman and the Rapporteur
3. Adoption of the agenda and programme of work
4. Report on the progress of the Eastern Mediterranean Region's research programme, May 1991 - April 1993
5. Report on the Task Force visits to Morocco and Tunisia (February 1992)
6. Highlights on the latest global ACHR Meeting, September 1992
7. Diseases of modern life-styles
8. Health aspects of human ecology (including health of immigrants, refugees, displaced populations, etc.)
9. Health of adolescents
10. Report on the progress of the WHO Special Programme for Research, Development and Research Training in Human Reproduction
11. Discussion of the draft report and recommendations
12. Any other business
13. Closure of meeting

Annex 2

PROGRAMME OF WORK

Saturday, 10 April 1993

09.00 - 09.30	Registration
	Opening Ceremony
09.30 - 09.45	Address by H.E. the Minister of Health, Dr Eyad Chatty
09.45 - 10.00	Address by Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean Region of WHO
	Election of Vice-Chairman and Rapporteur
10.30 - 11.30	Adoption of Agenda and Programme of Work
	Progress report on the Eastern Mediterranean Region's research programme, by Dr S. Mahgoub
11.30 - 12.30	Report on the Task Force visits to Morocco and Tunisia, (February 1992), by Dr M. Abdussalam
12.30 - 13.15	Highlights on the latest global ACHR Meeting, September 1992, by Professor Mamdouh Gabr
13.30 - 14.00	Diseases of modern life-styles, by Dr A. Alwan

Sunday, 11 April 1993

09.00 - 10.00	Health aspects of human ecology (including health of immigrants, refugees, displaced populations, etc.), by Ms T. Tuhkanen
10.00 - 11.00	Health of adolescents, by Dr R. El Ali
11.30 - 12.30	Report on the progress of the WHO Special Programme for Research, Development and Research Training in Human Reproduction, by Dr E.O. Akande

Monday, 12 April 1993

10.00 - 13.00	Review of the draft report and recommendations Suggestions for agenda, and time and place of the eighteenth session of EM/ACHR Any other business Closure of the Meeting

Annex 3

LIST OF PARTICIPANTS

MEMBERS OF EM/ACHR

Dr Adnan Abdel Halim Abbas
Secretary-General
Ministry of Health
Amman
JORDAN

Dr Mohammad Abdussalam
c/o Bundesgesundheitsamt
Berlin
GERMANY

Professor Ibrahim Beit Al Mal
Assistant Professor of Paediatrics
Faculty of Medicine
Al Arab Medical University
Benghazi
LIBYAN ARAB JAMAHIRIYA

Dr Othman Abdul Aziz Al Rabieah
Adviser to the Minister of Health
Supervisor, Medical Research
Ministry of Health
Riyad
SAUDI ARABIA

Dr Othman Abdel Malek Babiker
Vice-Chancellor
Wadi El Neel University
Chairman, Medical Research Council
Khartoum
SUDAN

H.E. Dr Eyad Chatti
Chairman, EM/ACHR
Minister of Health
Damascus
SYRIAN ARAB REPUBLIC

Dr Iradj Fazel
President
Academy of Medical Sciences
Teheran
ISLAMIC REPUBLIC OF IRAN

Dr Abdulla Ahmed Guneid
Dean
Faculty of Medicine and Health Sciences
University of Sana'a
Sana'a
REPUBLIC OF YEMEN

Dr Wafik Ashraf Hassouna
President
Sinai Health Systems Consultation Group
Dokki, Cairo
EGYPT

Major General Iftikhar Ahmad Malik
Chairman
Pakistan Medical Research Council
Islamabad
PAKISTAN

Dr Moncef Sidhom
Director, Primary Health Care
Ministry of Public Health
Tunis
TUNISIA

Mr Nicos Symeonides
Permanent Secretary
Ministry of Health
Nicosia
CYPRUS

Dr Mohammad Reza Zali
Deputy Minister for Research Affairs
Ministry of Health and Medical Education
International Relations Department
Teheran
ISLAMIC REPUBLIC OF IRAN

Resource Persons

Dr Reyad Amin El Ali
Jabal Alhussein
Amman
JORDAN

Dr Mirza Arshad Ali Beg
Member, Executive Board
Pakistan Council of Scientific and Industrial Research
Karachi
PAKISTAN

Professor Ibrahim Salti
Acting Principal
American University of Beirut
Beirut
LEBANON

Ms Tuula Tuhkanen
Lecturer
University of Kuopio
Kuopio
FINLAND

WHO ADVISORY COMMITTEE ON HEALTH RESEARCH

Professor Mamdouh Gabr
Chairman, WHO/ACHR
Secretary-General
Egyptian Red Crescent Society
Cairo
EGYPT

WHO Secretariat

Dr Hussein A. Gezairy
Regional Director
EMRO

Dr A.M. Abdul Hadi
WHO Representative to the Syrian Arab Republic
Damascus

Dr S. Mahgoub
Regional Adviser, Research Promotion and Development
EMRO

Dr E.O. Akande
WHO Special Programme for Research, Development and Research Training in Human Reproduction
WHO
Geneva

Dr A. Alwan
Regional Adviser, Noncommunicable diseases
EMRO

Mrs L. Korayem
Secretary
EMRO

Mrs N. Kenawy
Secretary
EMRO