

TOWARDS HEALTH FOR ALL BY  
THE YEAR 2000 IN THE EASTERN  
MEDITERRANEAN REGION OF  
THE WORLD HEALTH  
ORGANIZATION

مؤسسة الصحة للجميع بحلول عام 2000  
في إقليم منظمة الصحة العالمية لشرق  
البحر الابيض المتوسط

VERS LA SANTE POUR TOUS EN  
L'AN 2000 DANS LA REGION DE  
LA MEDITERRANEE ORIENTALE  
DE L'ORGANISATION MONDIALE  
DE LA SANTE

EMR Newsletter No. 10  
July-August 1981

#### WHO CONSULTANTS ON THE TRAIL...

At any given time, all year round, WHO consultants are visiting countries in the Region to assess various aspects of the public health situation in an attempt to help Governments face their health problems and solve them to the best of their possibilities and with the resources available. For instance...

...in Oman, Sudan, Yemen, two of them look for spots in children's eyes, the sign of xerophthalmia;

...in Pakistan, one of them attempts to determine the amount of blind people in the population in order to advocate measures to prevent avoidable evils;

...in Egypt, Kuwait and Sudan, another one is reviewing social work programmes to try and adapt them to mental health care;

...in Somalia, another one assesses the progress of the Expanded Programme of Immunization;

...in the United Arab Emirates, one of them notices that malaria can be an imported and man-made disease;

...in Libya, a lady consultant devises measures in cooperation with government authorities to educate the public about their own health.

In other places, other WHO consultants are discussing health problems and future plans with Ministries of Health in the capital city or journeying through bush and desert, djebels and rural areas, visiting dispensaries, schools, refugee camps, etc.

IN THIS ISSUE...you will read about some of their views and findings.

## VITAMIN A DEFICIENCY

Xerophthalmia ("dry eye") is a nutritional deficiency due to the lack of Vitamin A in the diet which every year leads to blindness in hundreds of thousands of children throughout the world.

Although relatively less frequent in the Eastern Mediterranean than in other parts of the world (Africa, Asia), public health authorities in the Region pay great attention to its possible prevalence within their prevention of blindness programmes. Thus two WHO Consultants visited three countries earlier this year, namely : Oman, Sudan and the Yemen Arab Republic, with the mission of carrying out assessments of Vitamin A deficiency in these countries by gathering information in the course of interviews with local health personnel and school teachers, review of medical records where and when available, field search for actual or scarred cases (including the early sign of avitaminosis A : night blindness, i.e. poor sight in the dark), enquiries on nutritional habits, as well as on disease and death rates, especially in children, and the presence of protein-energy malnutrition generally.

In some places night blindness was reported and the very sign of the disease (a spot in the eye called Bitot's spot) somewhat exceeded the critical level set by WHO and the International Vitamin A Consultative Group (IVACG), showing that xerophthalmia, although not being of disturbing significance, nevertheless should be given the consideration it deserves, particularly in preventive health services and community medicine.

Being due to malnutrition, the disease can be easily prevented by introducing into the daily diet, especially in the meals prepared for children, those foodstuffs which provide elements generating Vitamin A such as locally available green and yellow vegetables, salads and fruits, too often ignored, neglected or even despised in favour of can and tin foods. The main providers of Vitamin A are: garden rocket, sometimes called "jarjir" in Arabic, jews mallow ("mollokhiya"), carrot, pumpkin, purslane, chives and mango, which everybody can buy on the market place or grow in family or school gardens. Other products such as butter, cheese, eggs, and particularly liver, also contain a more than sufficient amount of Vitamin A, but they are much more costly and not everybody can afford them in a poor subsistence diet. Red palm oil is also a good source of Vitamin A.

In case of emergency, or in particularly critical situations, the distribution of a massive oral dose of Vitamin A in the form of capsules (100,000 to 200,000 IUs) at three or six months intervals to all children below the age of three constitutes the best possible protection against the threat of blindness due to xerophthalmia. Such capsules have been provided by WHO and UNICEF in many occasions. The primary health care worker would be in a suitable position to handle the distribution according to needs.

## PREVENTION OF BLINDNESS IN LIBYA

Xerophthalmia is a relatively limited problem of Ministries of Health setting up Prevention of Blindness Programmes (PBL) in the Region. Other problems are much more important and widely prevalent.

In the Libyan Arab Jamahiriya, another WHO Consultant assisted on two occasions, in 1980 and 1981, in the implementation of the National Prevention and Control of Impaired Vision and Blindness Programme.

In Libya, at present, twenty-five Eye Diseases Control Centres already exist at the "murakabat" (district) level. Regional centres are established in Tripoli, Benghazi and Sebha. All "murakabat" centres offer treatment for trachoma and screening for defective vision and glaucoma. The Libyan national programme aims at preventing blindness and visual impairment in the population through the control of trachoma, glaucoma, injuries and cataract. In particular, pre-school children are treated for trachoma in Maternal and Child Health (MCH) centres.

Since it is the intention of the Libyan public health authorities to control major causes of blindness through primary eye care, this will include curative (therapeutic) and preventive activities which will necessitate the training of primary health care (PHC) workers at Eye Diseases Control centres to give treatment for such conditions as trachoma, conjunctivitis, superficial foreign bodies in the eye and light injuries. These workers will take part in screening for trachoma, glaucoma, squint and cataract. They will have to refer cases short of their competence such as severe eye injuries, corneal ulcer or visual loss. As members of the PHC team, they will also help to promote personal eye hygiene in the community.

#### PREVENTION OF BLINDNESS IN PAKISTAN

Pakistan - where it is estimated that 2 to 4 per cent of the population are blind, although no accurate figures are available - is attempting to develop a national plan for prevention of blindness (PBL). Causes of blindness in the country are mainly cataract\* (60%) and trachoma infection resulting in corneal scarring (25%). Malnutrition, glaucoma and various other causes account for the rest. It is estimated that approximately 1 200 000 people are unnecessarily blind from cataract and half a million from trachoma and its sequelae. If it were possible to do something about these two conditions, at least 85 per cent of blindness would be prevented. Most ophthalmologists practice in towns and cities whereas 80 per cent of the population - and most of the blind people - live in rural areas.

#### President's statement

Pakistan decided to tackle the problem once more in September last (1980) when President Zia-ul-Haq expressed the Government's policy in declaring: "All efforts, therefore, should be doubled to restore eyesight to the maximum number of people". A few weeks later, a WHO Consultant arrived in the country to discuss with the national authorities the formulation of a new plan for the prevention of blindness.

Among his recommendations - and apart from a nationwide survey to determine the magnitude, distribution and causes of blindness - he advocated the training of medical technicians in primary eye care, so that these para-medical personnel may effectively deliver eye care at the basic health unit or dispensary level. Thus a permanent infrastructure would be set up for a community-oriented eye health scheme.

./.

---

\* In fact, cataract is not preventable, but can be successfully operated in eye camps at a cost which should not exceed \$ 5.

It is ultimately planned to train approximately 25 000 medical technicians who will work as multipurpose health workers in rural health centres and basic health units. They are to perform basic curative, preventive and promotive tasks. Whereas they will be supervised by medical officers, they will in turn supervise community health workers, thus applying one of the fundamental principles of primary health care (PHC).

The WHO Consultant also recommended to use school teachers to test children's vision at least twice during their education, as well as the further sponsoring and expansion of the endeavour known as the "Low Cost Spectacle Programme", an application of appropriate technology. Through this programme, those children who are truly unable to afford spectacles will receive them free.

#### MENTAL HEALTH AND SOCIAL WORK

Until now and in general, the role that the social worker can play in the achievement of "Health for All by the Year 2000" has been neither fully recognized nor described. And yet it could become more substantial and more visible. Social workers themselves now recognize that in the past they have missed opportunities to influence factors that are related to promotion of health and prevention of disease. Consequently, more should be done in the future to use social work expertise to modify the psychosocial factors associated with the transmission of common diseases and to promote adequate nutrition and sanitation, particularly at the primary health care (PHC) level. Social workers should also be called upon to play their part in the mental health approach to the community, especially if mental health care is to be extended to the periphery, as is not yet the case, or too seldom, in our Region.

A WHO Consultant, therefore, recently visited three countries in the Region, namely Egypt, Kuwait and Sudan, in order to review social work programmes in the light of mental health care and to advise on the development of relevant training programmes for psychiatric social workers, both professional and auxiliary. The ultimate aim of his mission was to find ways and means of strengthening social work's role in PHC and of extending mental health services to the peripheral urban, rural and even nomadic areas.

Several potential sites for institutional and field training of social workers in mental health care were identified by the WHO Consultant in the course of his mission, particularly opportunities for on-the-spot community training in Egypt and Sudan, in one case in collaboration with religious leaders. As far as institutional training is concerned, special student status is available at many universities within the Region, including Khartoum. The University of Kuwait, for instance, comprises a well-developed Department of Sociology and Social Work and social work is established as one of the significant human services in the country. Such opportunities should be exploited to the full, also for the benefit of mental health care in the community at large, and not only in hospitals.

Advocating the increased use of social workers in the mental health team, the WHO Consultant summarized some of his or her tasks by defining these workers as primary therapists working with the entire family to offer support and stimulate change, promoting involvement between the patient and his home and community, designing and coordinating programmes of everyday (therapeutic) care. More generally speaking, social workers could act as collaborators in general and especially PHC health care programmes, as well as community agents promoting self-care and preventive practices.

Stressing that social work activity was highly relevant to WHO's work and mission, one of the Consultant's recommendations was that, particularly in the mental health field, this Region should recruit candidates from the social and behavioural professions as well as from the medical profession.

#### MENTAL HEALTH RESEARCH IN THE EASTERN MEDITERRANEAN

All human societies have to share the burden of mental illness. There is no doubt that the pattern and manifestations of mental disorders differ in communities of the developing world from what they are in industrially advanced countries. In developing countries, due to cultural heritage, beliefs and traditions, people usually accept their mental patients, even if the latter become chronic and an economic burden. Nevertheless, in case of constant manifestations creating social disturbance, the family may lose patience and reject the mental patient. This will not, however, happen if the patients are given help before it is too late, for instance through primary health care (PHC). Mental illness patterns and methods of treatment have thus to be carefully researched in the Region.

#### Past and present

During the first half of this century, information regarding the nature and extent of mental disorders in countries of the Eastern Mediterranean was seriously lacking and often misleading. The scant knowledge, when available, was mainly based on inadequate statistical data collected from isolated mental hospitals, asylums or prisons. More recently, however, during the last two decades, with the growing movement from protective\* and custodial care to community-based services, considerable interest has been generated to study the mass aspects of mental illness, and to develop research methodology in the psychiatric field.

#### A Scientific Working Group on Mental Health Research

Seventeen participants from four countries in the WHO Eastern Mediterranean Region (Egypt, Kuwait, Pakistan and Saudi Arabia) took part in a Scientific Working Group Meeting on Mental Health Research held in Karachi in June last.

The Eastern Mediterranean Regional Committee on Biomedical Research, at its fifth session in Cyprus in September 1980 (see our EMR Newsletter No. 2, November 1980) already agreed with most of the proposals for research in the mental health field presented by WHO, in particular for epidemiological and social studies, as well as for research in the field of mental health services. This included such subjects as, for instance, the prevalence of psychiatric disorders in communities (incl. rural and nomadic), emotional disorders of children (incl. bed-wetting), studies of migrant labourers, conditions of admission into psychiatric institutions, or the role of traditional healers in the delivery of mental health care. All these items were discussed in the course of the Meeting.

./.

---

\* (to protect the society, not the patient)

Conclusions and recommendations

In its conclusions and recommendations, the Karachi Meeting put emphasis on training programmes and strengthening of local resources, as well as on collaborative research work among countries concerned (TCDC), and the elaboration of appropriate technology and culturally-oriented working tools.

One or two of the detailed recommendations made by the Meeting dealt with day-to-day concerns of health services in any given country, such as patients suffering from psychoneurosis or psychosomatic disorders who are crowding general health services consultations and wards where the health workers are not properly trained to deal with their problems and tend to resort to unnecessary clinical investigations and prescription of drugs. Research should thus be directed towards the development of methods and training programmes to deal with such patients, with a view to refer them to primary health care (PHC) services.

The Meeting also recommended that, with the increasing emphasis on treatment of chronic mental patients in the community, in order to prevent or at least to reduce their long stay in psychiatric hospitals, the role of the family in supporting their chronically or recurringly mentally diseased members should also become a subject of research.

QUOTATION BY H.E. DR NASIRUDDIN JOGEZAI, Minister of Health, in his inaugural address:

... "We are a poor country with limited resources and unlimited problems in health. We cannot afford to copy the developed nations and if we try the efforts are usually frustrating. In the field of mental health there is a great scope to make use of our traditional and cultural environment. The kinship among the family and acceptance of such patient by near and distant relations can be used to treat and manage them at a very low cost. What I am trying to convey is that we cannot afford big mental hospitals. We have to rely on community mental health and the community must be given the confidence through trained manpower who are prepared to leave the cosy and protected forts which we call hospitals."

\* \* \* \* \*

MALARIA IN THE UNITED ARAB EMIRATES

A WHO Consultant in malaria visited the United Arab Emirates (UAE). He reports that progress witnessed in the fields of education, health, public works, construction, agriculture, tourism and commerce has a positive impact on the health of the population and on the prevention of various diseases, including malaria. There is no doubt, he says, that such a progressing socio-economic development, coupled with appropriate technical guidance in the field of preventive medicine, will contribute toward eliminating most endemic diseases in less than a decade. The Malaria Section in the Department of Preventive Medicine of the Ministry of Health has been strengthened so as to fulfil its essential role in the planning, implementation and evaluation of the anti-malaria programme, and in elucidating the epidemiology of the disease, thus permitting to forecast any malaria occurrence in the Emirates.

./.

The main malaria problem in the UAE is the high number of imported cases among immigrant labourers from Asian malarious countries such as India, Bangladesh and Pakistan, as well as a few cases from neighbouring countries. These far exceed those notified among the local population and pose a continuous threat in generating malaria flare-ups everywhere local mosquito vectors are able to breed.

Also the extensive earth disturbance, due to economic progress and resulting from excavations for the building of roads, residential areas, etc. is producing potential breeding places near human habitations where seepage and rain water accumulate.

Also the rapid agricultural development (doubling the agricultural surface in the last five years) and the associated endeavours in tapping groundwater and digging irrigation systems, combined with the hiring of farmers from malarious Asian countries, all these factors contribute to making malaria a man-made disease.

On the whole, one can say that all the elements enabling the operation of an effective anti-malaria programme in the Emirates do exist. The malaria incidence is appreciably decreasing in the country with a few exceptions in remote areas. The capital cities of Abu Dhabi and Dubai have active municipalities carrying out effective mosquito control. These vector control activities should also, nevertheless, include engineering works, e.g. filling up all depressions left by construction works and low-lying areas where mosquitoes breed. The example of Abu Dhabi spending over 60 million dirhams on such works reflects the concern of its Municipality and its farsightedness.

If the socio-economic progress of the country has a favourable impact on the incidence of malaria, the resistance of some uncooperative communities to anti-mosquitoes measures at breeding places or in their houses hampers the progress of the programme. This negative attitude can only be overcome by appropriate information and education of the public.

Administrative and management support to the anti-malaria programme is good. In the field of training, the UAE Malaria Section conducts vocational training (on-the-job training) for supervisors or technicians in the fields of entomology, parasitology, operations and epidemiological investigation. Starting next year, three or four such courses will be organized, not only for local staff, but also for candidates from other Arab States of the Gulf.

#### PROGRESS OF THE EXPANDED PROGRAMME OF IMMUNIZATION IN THE REGION

From 1974 to 1980 the number of children receiving a full course of diphtheria, pertussis and tetanus (DPT) and those receiving the trivalent oral polio vaccine (TOPV) has more than quintupled in the WHO Eastern Mediterranean Region. Although the number of live births, in the Region, has increased from some nine millions in 1974 to about 10.5 millions in 1981, the percentage of children under one year of age vaccinated against these four diseases has increased from 3.9 to 22.6 per cent. The achievement in respect of measles vaccine is similar.

If during the rest of the 1980s, anything like the degree of expansion which occurred from 1974 to 1980 can be sustained, it seems probable that the 1990 target of EPI - all children vaccinated against the six main childhood diseases (diphtheria, pertussis, tetanus, polio, measles and tuberculosis) within the next ten years - this target will be reached in the Region.

On the whole, slight decreases in the number of cases of some of the six target diseases have been registered before and as from 1979. One would like to think that this represents an improving situation due to the results of the immunization programmes. It may just possibly be that we are beginning to see the very early signs of a fall in the frequency of some of these diseases, although reporting of cases is still far from complete in many countries due to lack of reliable statistics.

The countries in the Region have some reason to be satisfied with the progress of the Expanded Programme of Immunization. The main tasks for the 1980s are to steadily sustain the increase in coverage well beyond the limits of present health services. In some cases, therefore, EPI will have to be a vanguard component of primary health care (PHC). If evaluation of the progress is to be ascertained, this also means developing epidemiological surveillance of all six diseases until it provides a reliable measure of the ultimate effectiveness of EPI.

#### EPI IN SOMALIA

A WHO Consultant coming back from Somalia reported that the national plan of action for EPI in this country, prepared in 1979, had for objective the vaccination of 70 per cent of children under 5 years against the six target diseases until 1985, so as to considerably reduce the toll of disease and death in the infantile population. To help this, 70 per cent of women of reproductive age will also be vaccinated against tetanus, so as to avoid tetanus of the new born (neonatal tetanus). It was also planned that new Maternal and Child Health (MCH) centres in the districts would take over EPI activities by increasing their staff in relation to population.

#### RESEARCH MANAGEMENT

It has too often been said in the past that research (fundamental and applied) was a luxury that developing countries could not afford. To deny this, WHO has constantly endeavoured to improve medical and health research facilities in the Region (see among others Newsletter No. 8, May 1981). Nevertheless, it soon became apparent that, in promoting research activities, a major constraint was the lack of expertise in managing research institutions and programmes, and in ensuring the effective utilization of the scarce human and financial resources available for medical research in developing countries.

#### Objectives

A score of participants from Egypt, Iran, Pakistan and Sudan, therefore took part in a Workshop on Research Management which was held in Islamabad, Pakistan, in April last. The broad objectives of the Workshop were:

- to study the scientific approach to the management of medical research in general;
- for the participants to commit themselves to promote and carry out this approach in their own country, having acquired sufficient knowledge in order to apply and disseminate it in their own work;
- to develop criteria for the assessment of research management practices in their own institutions or countries, and finally,
- to acquire the ability to organize and conduct in their turn national workshops on research management, thus applying the WHO basic principle of "teaching learners to teach other learners" with a snowball effect.



### WHO's aim

WHO's aim in setting up such workshops is to improve the planning and implementation of national medical research programmes, utilizing the available and appropriate management skill within the existing administrative structure. Such workshops will eventually lead to further strengthening of research management capabilities in each country in order to enable them to formulate research plans commensurate with national needs and resources.

### HEALTH EDUCATION AND INFORMATION OF THE PUBLIC

It is striking to note that in their reports almost all WHO Consultants visiting countries and working in the field stress the need for information and education of the public. In the Eastern Mediterranean Region as in others, Governments cannot tackle all health problems at the same time with their limited human and financial resources. Thus the PBL consultant in Pakistan notes that there is a general need to educate the public "to seek attention at the first sign of reduced vision and not to wait until one is totally blind." Radio and TV programmes, he thinks, should also deal with eye health in a similar fashion to the current literacy and agriculture programmes. In blindness as in so many other conditions of ill-health, most causes are avoidable and could be prevented through appropriate technology in information and education.

In the United Arab Emirates, another WHO consultant also deplors the lack of information and education of the public, especially regarding the refusal of certain communities to let malaria workers treat their irrigation reservoirs and wells in their gardens to kill mosquito larvae, or the spraying of their houses with insecticides yet to protect them. Very few health education/information activities are performed by the health personnel and others, particularly in the schools, and in problem areas with high refusal rates regarding anti-malaria measures.

Some countries, nevertheless, have taken into consideration the necessity of boosting health education and public information activities. Thus a WHO consultant visited the Libyan Arab Jamahiriya earlier this year, at the request of the Government, to advise the Libyan Secretariat-General of Health and of Education on the possible initiation of a national programme of health education, including in the schools. The programme is envisaged to be carried out in cooperation and in collaboration with other Secretariats (Ministries), services, organizations and groups whose activities can assist in increasing the knowledge and understanding of individuals and communities in matters of health, and in helping them to help themselves (self-help) to achieve a better health status, according to the PHC principles.

Since the Al-Fateh Revolution in 1969, Libya has made tremendous efforts to improve its national education systems. Authorities now wish to give priorities to the introduction of technical and vocational subjects into the preparatory and secondary school curricula. Health education could be one of them.

The purpose of a health education programme is that the individual, the family and the community can and should take measures to promote health and prevent disease. For this it is essential that knowledge and understanding be brought to them in terms that fit their cultural background, so that what is taught them can be better understood and adopted. Those in permanent contact with the communities, like the PHC workers, are in the best position to ensure this provided they are trained and supported in these activities.

./.

The WHO consultant recommended the creation within the Secretariat-General of Health of a Health Education Department which would have the functions of organizing a health education service in Libya, whose activities would be divided in three sectors, namely : school health education; the use of audiovisual aids; staff training and applied studies.

The Department should effect liaison with other Departments within the Secretariat-General of Health and with those of Education, Agriculture (especially Agricultural Extension services) and Community Development, as well as with other bodies such as the general People's Committees, the Red Crescent Society, and organized labour in industry and mining; in short, with all bodies considered to have health-related functions. It is only by intersectoral cooperation that the best results will be obtained.

WITHOUT HEALTH EDUCATION AND INFORMATION OF THE PUBLIC

NO LASTING HEALTH PROGRESS WILL BE ACHIEVED

NOTE TO READERS AND EDITORS

For further information on these items please write to:

The Director  
Division of Public Information  
World Health Organization (WHO)  
20 Avenue Appia  
CH - 1211 GENEVA 27, Switzerland