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

نحو تحقيق الصحة للجميع بحلول عام ٢٠٠٠ في اقليم 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

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IN THIS ISSUE...

..PUBLIC HEALTH...PUBLIC HEALTH...PUBLIC HEALTH...PUBLIC HEALTH...PUBLIC HEALTH...PUBLIC HEALTH...PUBLIC

PUBLIC HEALTH IN THE YEMEN ARAB REPUBLIC

Second five-year (1982-1986) National Health Development Plan adopted

The Ministry of Health of the Yemen Arab Republic has adopted the draft of a second National Health Development Plan for 1982-1986, putting the emphasis on the development and expansion of primary health care (PHC) leading towards the achievement of HFA/2000 (Health for All by the Year 2000).

The population to be covered by the plan is 22 per cent of the total country population, i.e. about 1.87 million people.

The first five-year plan has already succeeded, among other things, in establishing a PHC Unit at the Ministry of Health; in appointing PHC responsible officers at governorate level in Hodeidah, Taiz and Ibb; in organizing training courses for PHC workers at the Health Manpower Institute, including at governorate level; in preparing manuals for these workers; and in following up and supervising the construction of PHC units all over the country.

WHO is collaborating closely with the YAR Government towards a shift from curative to preventive and promotional services through its support, over the past twenty years, of a generation of health personnel who has grown up and assumed responsibilities for public health services in the less privileged areas of the country. Several WHO advisers, working with local staff, have helped and are helping to accelerate the development of the PHC project. 39 PHC units are expected to start functioning shortly in Taiz, Zabid and Hodeidah.

An exciting enterprise

"The developing Yemen Arab Republic health service is an exciting enterprise", stated a WHO consultant who recently helped the Government review combined activities in the fields of primary health care, health manpower development and health education of the public, as they have common objectives and interests. The accent put by the Government is on building a viable health system in the face of immense barriers of geography, public unawareness, limited resources and shortage of trained manpower. The national plan must have an element of flexibility to suit local conditions, as the country has many regional differences in beliefs, customs and diseases.

Primary Health Care

Plans for a full national health service at present taking shape in the Yemen Arab Republic will include primary health care (PHC) as well as other services. The PHC movement should have a profound impact on the health of the nation. The main objective is the selection and training of young adults from rural areas who, after a period of three months training, are relocated back in their villages to perform preventive and promotional health activities and simple health care.

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Health Manpower Development

Important to the development of PHC is the role of the Health Manpower Institute in Sana'a. A series of training programmes were held there from January 1981 to prepare trainees/supervisors of PHC workers through 6-week practical and appropriate training courses. Since then, a PHC workers training programme of six months duration has begun in five health centres in three governorates with 65 trainees taking part. The first batch of PHC workers should graduate around November 1981. The quality of the trainees and of the Institute reflects the soundness of the 13 programmes organized and held at the HMI for the training of nurses, technicians, medical assistants, pharmacists, etc. The training of local birth attendants has also begun, with nine women in training. For all these trainees, the WHO/PHC Workers Manual now available in Arabic is a valuable instructional document.

Health Education and Information of the Public

Health education is seen as a way of overcoming the lack of understanding on the part of the public about matters of health and the promotion of PHC. The YAR health education project is well established and expected to contribute to all aspects of the health service. The WHO adviser specialized in this field also teaches at the HMI and contributed to the production of the PHC Manual in Arabic.

The same WHO consultant was of opinion that a major campaign should be conducted via national TV, radio and newspapers, to orientate the public to the concept, aims and methods of PHC and that this campaign should run for at least a year. It should not look at diseases and problems in isolation, but purposely develop the concept of the YAR/PHC system, stressing the role which the villagers can play in operating and using it. The emphasis should be on showing PHC workers, local birth attendants, sanitarians, vaccination personnel, etc. talking about their own jobs. Field visits should replace tedious TV interviews. The notion of community development and participation could be highlighted. To achieve this purpose, health educators should work closely with PHC field staff in schools and villages. It is by contact and dialogue between heath workers and villagers that behavioural change is more likely to be accomplished.

Television has already a major thrust in the national health education programme. Every week, a 20 to 30 minute health programme is presented, as well as occasional short promotions (TV spots).

PUBLIC HEALTH ACTIVITIES IN LEBANON

In spite of the difficult circumstances and constraints prevailing in Lebanon, the World Health Organization (WHO) was nevertheless able to maintain close collaboration with the Ministry of Health, the Council for Development and Reconstruction (CDR), other bodies and agencies of the UN system - particularly UNDP and UNICEF - and several non-governmental organizations in pursuit of health related programmes in the country. WHO technical cooperation was particularly required in the planning of reconstruction and re-equipment of hospitals in the South, the building of health centres and dispensaries and the formulation of their activities, especially promotive and preventive, as well as the training of personnel.

In the course of 1980-81, WHO has provided some US$ 944 600 from its regular budget for the reorganization and development of health services in Lebanon, out of which more than a quarter was devoted to fellowships.

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The National Waste Management Plan project, funded by UNDP and executed by WHO, has succeeded until now to adhere to the scheduled plan of action. The objectives of the project are:

-- to protect the water resources of Lebanon;

-- to improve the sanitary conditions of the country;

-- to prevent degradation of the environment and to eliminate all factors related to the environment which may affect socio-economic progress.

Emergency operations for the provision of blood sera, antibiotics and surgical rooms equipment amounted to some US$ 100 000.

It is expected that all long-term activities in the field of health development will continue in 1982. In addition, WHO is expected to join efforts with UNDP and the Faculty of Health Sciences of the American University in Beirut in contributing to the setting up of a network of community health centres in the country, including the training of community health workers.

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HEART DISEASES IN EGYPT

Egypt is undergoing rapid socio-economic changes which also affect the health of the nation. The country is well on the way towards the pattern of industrialized nations where cardiovascular diseases (CVD) are by far the most common cause of death. Mortality from these diseases shows a steady, alarming rise in Egypt since the 1950s. Until the mid-fifties, the CVD mortality rate remained rather stable. However, since 1956, the rate rose and more than doubled in 1975.

Recent data show hypertension (elevated blood pressure) as the most important cause of CVD deaths. To hypertension are also attributed most deaths due to cerebrovascular accidents (strokes). Then comes rheumatic fever and its sequel, rheumatic heart disease. Ischaemic (or coronary) heart disease comes next and quite close. The Government intends to undertake an epidemiological study, during the period 1981 to 1983, in selected governorates, as part of the project "Health Profile of Egypt".

Hypertension

The frequency of hypertension in Egypt has been studied. Quite high rates have recently been observed: up to 16 per cent among rural men of 40 years or older, and 22 per cent among Cairo city bus drivers.

No definite means for the primary prevention of high blood pressure are as yet known. The only way to know is to have your blood pressure taken in a proper way. An excessive intake of salt is now widely suspected as one of the possible causes. According to this hypothesis, a low salt intake (up to 4-6 gms a day) would exclude hypertension, but a high salt intake alone would not necessarily cause it. The salt intake in Egypt is traditionally high (15-18 gms a day). The country thus ranks among the largest consumers of salt in the world. It is believed that hypertension was previously rare in Egypt. Probably factors other than salt are also responsible for its recent increase. They may well be psychosocial factors.

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Modern drugs make it possible to keep the blood pressure of hypertensive patients within normal limits in the majority of cases. Studies in several countries show, however, that customary medical services have failed in the control of hypertension in the community. However, major improvements have been achieved against hypertension in pilot projects, or by integrating anti-blood pressure treatement within primary health care. Even lacking clear-cut primary ways to prevent it, hypertension is today controllable.

Rheumatic fever and rheumatic heart disease

Rheumatic fever develops as a result of sore throat with streptococcal infection in a small percentage of patients. It often damages the heart and may lead to rheumatic heart disease. Rheumatic fever has over the past 50 years virtually disappeared from the developed industrial nations, and so has also rheumatic heart disease. In some countries, the incidence of rheumatic fever had vanished already before the era of antibiotics, while in others the introduction of these seems to have turned the tide. In Egypt, however, both diseases still are a major problem. Most cases of rheumatic fever occur between the ages of 6 and 12 years. Several important epidemiological studies have been carried out in selected Egyptian communities. The natural history of the disease in Egypt has been accurately described and analyzed. Research in this field is of the highest international standard.

Rheumatic fever and rheumatic heart disease are preventable. Studies carried out in the country show that current antimicrobial prophylaxis with penicillin is as effective in Egypt as elsewhere. With more effective prophylaxis in primary health care, improved results should be expected.

Ischaemic (coronary) heart disease

Commonly known as myocardial infarction, ischaemic (coronary) heart disease (IHD) develops as a result of a life-long progressive narrowing of the coronary arteries through atherosclerosis. Thrombosis is an often superimposed acute exacerbating event of this slow process, leading to necrosis of that part of the heart supplied by the coronary artery. Both these types of episodes may be fatal.

IHD is currently the most important health problem of the middle-aged and the old in the majority of industrial countries, where it is responsible for up to half the total deaths. It has increased, like an epidemic, over the last 50 years and still is spreading, affecting progressively younger age groups. Men are more prone to IHD than women.

The disease has a multiple origin. Eating too much fat is one likely cause. In epidemiological studies in many parts of the world, high blood cholesterol, high blood pressure and cigarette smoking have proved to be the major predictors of IHD. Some studies of IHD and of its risk factors have already been carried out in Egypt. The risk factors studied were blood cholesterol, blood pressure, cigarette smoking and obesity. In fact, prevention of IHD is a way of life.

In Egypt, finally, schistosomiasis may be among other causal factors in the occurence of cardiovascular diseases.

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A national project for Egypt

At the request of the Egyptian Government, a WHO consultant contributed to develop a comprehensive national project for the epidemiology and control of these diseases in the country. Broadly speaking, the objectives of a community programme involve the care, prevention and rehabilitation of patients suffering from cardiovascular diseases; the primary prevention, when possible, of CVDs; and the promotion of cardiovascular health. Means exist for the control of the major conditions described above. Nevertheless, the main objective of the project should be in the first instance an assessment of the main hazards to the cardiovascular health of the Egyptian nation in order to bring a reduction of premature loss of health and human lives.

In the same disease context, another consultant was delegated by WHO to assist and advise in the planning of intensive care, particularly coronary care, at the new University Hospital of Assiut in Upper Egypt. WHO has contributed substantially to the development of other such units over several years, since they were first introduced.

BRIEF NEWS...BRIEF NEWS...BRIEF NEWS...BRIEF NEWS...BRIEF NEWS...BRIEF NEWS...BRIEF

THE REFUGEE PROBLEM IN SOMALIA AND SUDAN

The refugee problem will again be taken up in the course of the next session of the WHO Executive Board scheduled to be held in Geneva, Switzerland, in January 1982. It is to be remembered that the Conference on Assistance to Refugees in Africa, which took place in Geneva in April last, was followed by a resolution of the World Health Assembly requesting WHO to continue and intensify its cooperation, within its field of competence, with the Office of the UN High Commissioner for Refugees (HCR) and other organizations concerned in the implementation and follow up of the conclusions of the Conference.

Africa is the continent most severely affected by the problem of refugees, who number about five million. Among the countries affected, two of them, Somalia and Sudan, are part of the WHO Eastern Mediterranean Region.

Somalia

In view of the particularly extensive refugee problem in Somalia, a WHO/HCR coordinator is responsible for multiple health activities in the country. This arrangement constitutes a model for very fruitful collaboration between the two organizations. Moreover, programmes for the control of tuberculosis, schistosomiasis and malaria are in progress, and primary health care services are in operation.

Sudan

WHO has recently carried out two major missions to evaluate the problem of displaced persons in Sudan. Programmes of public health, maternal and child health (MCH), vaccinations and primary heatlh care (PHC) have been set up.

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PROGRESS OF THE EXPANDED PROGRAMME OF IMMUNIZATION IN THE YEMEN ARAB REPUBLIC

The Expanded Programme of Immunization (EPI) in the Yemen Arab Republic was initiated in 1979 as a long-term integrated component of the health services. As in all other countries of the WHO Eastern Mediterranean Region, its objectives are to reduce the incidence of six of the main childhood diseases, namely diphtheria, pertussis, tetanos, poliomyelitis, measles and tuberculosis - by providing immunization against these to children from 3 months up to five years of age residing in the principal cities, towns and accessible rural areas.

The programme management is situated within the Department of Preventive Medicine and is implemented through the primary health care programme, supplemented by special mobile teams. Beginning at three months of age, three doses of DPT and polio vaccine, spaced at two-monthly intervals, are offered. BCG (for tuberculosis) is given on the first visit and measles is offered at the first opportunity between the ages of 9 to 30 months.

The EPI has been implemented in three phases. During the first phase, from January 1977 to June 1978, immunizations were begun in ten health units in the main cities of Sana'a, Taiz and Hodeidah. During the second phase, from July 1978 to June 1979, EPI reached three more governorate capitals and nine towns and villages. Ten other villages with health sub-centres situated on the main roads were also reached by outreach from two EPI established units. The population served was then approximately 500 000 or 9% of the total population. EPI entered its third phase in July 1979. At present, threre are 45 static units, six outreach teams and three mobile teams. The total population resident in areas covered by EPI is now about 700 000, or 12 per cent of the total population of the country.

TRAINING OF VILLAGE WATER OPERATORS IN THE YEMEN ARAB REPUBLIC

The Department of Rural Water Supply of the Yemen Arab Republic has for a long time realized the importance of manpower development in the field of operation and maintenance of rural water supplies facilities in order to ensure their continued, reliable and economic utilization.

It is in this context that WHO, in cooperation with the Government and the United Nations Development Programme (UNDP), initiated a programme to train pump operators and repair personnel at village level. 69 villagers have thus been trained in two different categories of courses (simple and advanced) during the period 1980-81. In November 1981, nine more village pump operators were trained and awarded certificates by H.E. the Minister of Public Works, who expressed on the occasion his appreciation of WHO and UNDP support.

DISCONTINUATION OF SMALLPOX VACCINATION

In May 1980, the World Health Assembly, pursuant to its declaration of global smallpox eradication, recommended as part of the post-smallpox eradication policy that vaccination should be discontinued in every country, except for investigators at special risk in laboratories. The majority of WHO Member States have now implemented this recommendation. Even countries with large populations, such as India and China, have recently informed WHO that vaccination is no longer obligatory. As of 12 November 1981, obligatory vaccination of the general public has been abandoned in 144 countries. Among the five countries which are known to continue obligatory vaccination, three of them, namely Egypt, Kuwait and Tunisia, are situated in the Eastern Mediterranean Region. While this information refers to internal vaccination policy, mainly of children, the practice of requiring a smallpox vaccination certificate from international travellers has now been discontinued by all countries except one.

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POLIOMYELITIS IN THE EASTERN MEDITERRANEAN

Although the reported number of cases of poliomyelitis in the Eastern Mediterranean in 1980 was higher than in the previous years (8299 in 1980 against 6256 in 1979), this was almost certainly due to the considerable efforts which have been made in the Region to improve surveillance. The gradual reduction in incidence apparent in 14 out of 24 countries and territories probably reflects the real situation.

The only country which has achieved freedom from polio in the Region is Cyprus. Good progress is being made in Kuwait. The incidence in Israel is very low, most cases occuring in rural pockets where environmental hygiene is not ideal. Cases are still occurring in the Occupied Territories. Jordan has already achieved coverage of about 70 per cent of children in the first year of life with three doses of oral vaccine. Although reporting is not complete, the incidence of polio appears to be falling in the country.

Improvements in programme management, training, equipment and coverage have become evident and all point to the Eastern Mediterranean being a Region in which major advances in polio control can be expected over the next few years.

CHOLERA AND THE MECCA PILGRIMAGE

Once again this year the Mecca Hadj pilgrimage has come to a close and no significant communicable disease situation has arisen. It is striking that straightforward simple effective surveillance has been the basis of bringing this about. No cholera vaccination certificates, for example, were requested from pilgrims, even though it was known that the presence of cholera had been reported from many of the countries from which they had come. A few imported cases and carriers were detected in both Medina and Mecca, but apart from one or two instances in Medina, no local transmission occured. This reflects the promptness of notification and investigation and the effectiveness of this approach even under difficult conditions which the sudden influx of some two million people represent. It also supports the belief that if approached in this way, the presence of cholera in a country need not lead to widespread transmission, nor justify restrictive measures with no epidemiological foundation to be taken by other health administrations. Saudi Arabia was declared free of cholera on 21 October last.