...NEWSLETTER...NEWSLETTER...NEWSLETTER...

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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69TH SESSION OF THE WHO EXECUTIVE BOARD OPENS IN GENEVA

The 69th session of the WHO Executive Board, which is expected to last three weeks, opened in Geneva, Switzerland, on 13 January 1982. Members from the WHO Eastern Mediterranean Region attending the Board are:

- Dr M.H. Abdulla, Director of Dental Services, Ministry of Health, United Arab Emirates and Dr A.R. Jaffar (alternate), Assistant Under-Secretary, Chief of Curative Medicine, Ministry of Health, United Arab Emirates;

- Dr A.R. Al-Awadi, Minister of Public Health, Kuwait, and Dr A. Al-Saif (alternate), Head, International Relations Division, Ministry of Public Health, Kuwait;

- Dr M.S. Al-Khadury, Minister of Health, Muscat, Oman, and Dr A.A.K. Al-Ghassani (alternate), Director, Department of Preventive Medicine, Ministry of Health, Oman;

- Mr K. Al-Sakkaf, Director, International Health Relations, Ministry of Public Health, Sana'a, Yemen, and Dr A.R. Ishak (alternate), Director, Medical Research Unit, Ministry of Public Health, Arab Republic of Yemen;

- Dr P. Rezai, Director General, Malaria Eradication and Communicable Diseases, Ministry of Health and Welfare, Teheran, Iran;

In addition, Mr E.A. El Reedy, Ambassador, Permanent Representative of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies in Geneva

and

Mr T. Madi, Counsellor , Permanent Mission of the Hashemite Kingdom of Jordan to the United Nations Office and Specialized Agencies in Geneva are expected to attend the discussions on the transfer of the Regional Office for the Eastern Mediterranean as Government Representatives by virtue of rule 3 of the Rules of Procedure of the Board.

New Regional Director appointed by the Board

In agreement with the Members of the WHO Regional Committee for the Eastern Mediterranean, the Executive Board has appointed Dr Hussein Abdul Razzak GEZAIRY as next Director for the Region as from 1 September 1982 for a period of five years. He will succeed Dr A.H. Taba whose fifth five-year term expires on 31 August 1982.

Born in Mecca in 1934, Dr Gezairy graduated in Medicine in 1957 at the Kasr El Aïni Faculty of Medicine in Cairo, where he also obtained his diploma in general surgery in 1960. He then joined the staff of the University of Riyadh, following which he undertook postgraduate studies in surgery as a Registrar at the Brompton and Royal Free hospitals in London, obtaining the Fellowship of the Royal College of Surgeons of London in 1965. He was then appointed as Founding Dean of the Faculty of Medicine of the University of Riyadh in 1966. He was also lecturer, assistant professor and associate professor of surgery in the same Faculty. In October 1975, Dr Gezairy became Minister of Health of the Kingdom of Saudi Arabia, a post which he has held since that time.

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Among many other activities, Dr Gezairy has taken part in sessions of the Council of Arab Ministers of Health; of the Council of Health Ministers of Arab States of the Gulf Area; of the World Health Assembly and of the WHO Regional Committee for the Eastern Mediterranean. Dr Gezairy was a Vice-Chairman of the WHO Ministerial Consultation on Health Services and Manpower Development in 1978, and is President of the Supreme Council of the Arab Board for Medical Specialization. He is a founder and promoter of medical studies in Saudi Arabia and a member of academic and medical conferences in the Arab World, UK and USA. His publications include research papers in surgery and medicine.

The Chairman and several members of the Board expressed their deep appreciation of Dr Taba's services and dedication during his 25 years as Director of the WHO Eastern Mediterranean Region.

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HEALTH PROGRESS IN THE SULTANATE OF OMAN

The celebration of National Day in Oman enabled public health authorities to proclaim that the country is well on its way to achieving health for all citizens by the end of 1985, according to Health Minister Dr Mubarak S. Al-Khadury.

A few figures

Apart from a growing number of hospitals and in addition to 14 health centres, there are now 55 clinics which include mother and child health (MCH) sections, 13 public health units and a number of mobile clinics. In the capital city of Muscat, there are central preventive medicine units for insect control, environment, communicable diseases, school health, health information, and mother and child care. There are also a bacteriology laboratory, a water analysis laboratory, and a school for training nurses. Nine quarantine units are functioning at airports, harbours and at the borders.

Second Five-Year Plan

The second Five-Year Plan aims at expanding the medical services in the "wilayats" and remote areas of the interior, creating a network of health centres, thus moving the health services to the rural areas. It also aims at expanding the preventive medicine programmes and at establishing a store of essential drugs.

Oman's health strategy is being implemented through a multidisciplinary approach. The Ministry of Health is responsible for the provision of preventive and curative services to cover the whole population and its duties include upgrading the existing services and extending the health care facilities to areas not adequately covered so far. Meanwhile other ministries share the burden in the fields of environmental sanitation and provision of community development facilities such as potable water, housing and sanitation.

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Trachoma and Malaria in Retreat

Two of Oman's most ambitious programmes are eradication of trachoma - the eye disease which may lead to blindness - and malaria. The chances of bringing them down very substantially indeed by the end of the current plan period are quite bright.

The Trachoma Control Programme already underway is being carried out in two phases: first at the school level and then at the community level. All school children in the country were examined and treated during 1980-81. The continuous programme aims at treating all newly admitted school children every year until the disease has completely disappeared.

In the second lapse of time, 67 villages in three districts will be dealt with by the end of 1982. The arrival of a WHO expert in January 1982 is expected to give further impetus to the programme.

A five-year plan (1981-1985) for the control of malaria is also underway. It includes establishment of some twenty malaria control stations in highly endemic areas. Five stations have been set up in 1981; another dozen stations will be established between 1982 and 1985. Two WHO technical officers and one malariologist are expected to be stationed in the Sultanate as from January 1982 to help extend preventive measures against malaria to all parts of the country.

HFA/2000 Strategy adopted

In the first few years since 1970, the Government gave priority to the development of widespread curative services. But since the First Plan and the adoption of the "Health for All by the Year 2000 (HFA/2000)" strategy, higher priority has been progressively assigned to the improvement of measures contributing to prevention of diseases. The Preventive Medicine Department has developed its activities steadily over the past few years with the establishment of national health programmes, particularly in the field of immunization; with additional health units to serve the interior area; with the training of local youth to become leaders of health promotion in their respective village communities; with the expansion of the Environmental Health Section to deal with water and sanitation projects; and with the promotion of health education.

Health Manpower Development

As in many other countries, one of the chronic problems holding up Oman's "healthy" ambitions is the shortage of personnel. As one contribution to meeting this challenge, the Government is setting up a Health Institute, work on which is scheduled to be completed by February 1982. It is expected to start functioning by September 1982 and will begin by training a group of middle level health workers, including nurses, laboratory and X-ray technicians and other public health personnel.

No white elephants

Oman is not going for massive, prestigious health projects which are impressive to look at but more often than not fail to deal with the basic needs of the population. As the WHO representative in Oman points out: "We have seen no white elephants in this country."

WHO is playing an important role in this respect through expert advice and by providing consultants on specific problems. There are at present 13 collaborative health projects in which WHO is actively involved.

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MATERNAL AND CHILD HEALTH IN SOMALIA

In cooperation with the Ministry of Health of the Somali Democratic Republic and UNICEF, a WHO team reviewed maternal and child health (MCH) activities, including the Expanded Programme of Immunization (EPI) in the country.

Government policies and objectives

The backbone of the MCH programme in Somalia consists of 75 MCH centres functioning all over the country, each of them staffed by a public health nurse or a midwife, or both. In 1977, a project for maternal, child and family health was initiated with funds from UNFPA and technical assistance from WHO. An expansion of the project is envisaged to cover 12 of the 16 regions of the country by 1985. The target is to have 54 new MCH centres.

To this should be added the primary health care (PHC) programme which has just started and which will cover the remaining four regions by 1985. The purpose of this programme is to build 21 health centres, 68 PHC units and 272 primary health posts, with one community health worker and possibly one trained MCH assistant at each post. These centres and units deliver comprehensive services with emphasis on MCH and nutrition.

The Government policies and objectives are that MCH and PHC services should be expanded to cover the whole population, and that they should include immunization, nutrition, health education and family planning (birth spacing). Breastfeeding is to be encouraged by all means, bottle and infant formula feeding discouraged, and proper weaning food introduced, as well as nutrition surveillance and demonstrations, and health education classes. The activities of these centres are mainly directed at high risk groups, pregnant women, mothers, and children under the age of four. Each MCH centre covers a population of about 20 000 people, most deliveries occuring at home with the help of a MCH assistant or possibly a public health nurse or midwife. In the new plan, every public health nurse/midwife is responsible for 200 families whom she is supposed to visit every month. She also supervises a number of trained MCH assistants who each are responsible for 200-250 families.

The Expanded Programme of Immunization (EPI)

The Expanded Programme of Immunization (EPI) was initiated in Somalia in 1978 in the Mogadishu Region. In 1979, immunization programmes were instituted in four other regions of the country. This was followed in 1980 by expansion to one or two rural districts in each region. At present, EPI is operating in 5 out of the 16 regions of Somalia. The population covered is 60 per cent of the country's total.

As in other countries, the long-term objective of the EPI plan of action is to reduce the amount of illness and death caused by six childhood diseases (diphtheria, whooping cough, tetanus, poliomyelitis, measles and tuberculosis) to such extent that, by 1990, these diseases would not represent any longer a public health problem.

The immediate objective is to cover 70 per cent of eligible children with the complete immunization schedule and 70 per cent of women in reproductive age with tetanus toxoid (TT) to avoid tetanus of the newborn, all this by 1983. Also, disease reduction targets are set to reduce illness and death due to measles, tetanus of the newborn and whooping cough by 70 per cent. The programme offers all vaccines for the six diseases.

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The team's recommendations

The nurses/midwives themselves expressing the need for periodic refresher training, the team agreed that especially those from outside the capital city should be entitled to such in-service training in order to keep them up-to-date with advances in MCH, immunization and family planning.

The most economical and appropriate way of extending the geographical coverage of immunization at present would be to ensure that throughout the country all MCH centres are able to provide the full schedule of childhood vaccination. This will require equipment including refrigerators, supplies, training and supervision.

In view of the occurence of tetanus of the newborn in Somalia, immunization of women of childbearing age needs to be given high priority.

Oral rehydration to combat diarrhoeal diseases should be implemented for young children in the MCH centres.

The staff responsible for EPI should also take responsibility for the vaccination programme of refugees.

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THE HEALTH OF AFGHAN REFUGEES IN PAKISTAN

At the request of the Government of Pakistan, a WHO consultant visited Afghan refugees to review their situation and suggest measures to improve their health.

Pakistan is the first country of asylum for an estimated 2.3 million refugees from Afghanistan. The influx of refugees from one country to another is the largest in the world and has steadily been increasing since 1978. 99 per cent of these refugees are registered in the North West Frontier and the Baluchistan provinces. WHO, FAO and UNICEF are the main UN agencies involved in assistance to the refugees, apart from the UN Office of the High Commissioner for Refugees (UNHCR) and the World Food Programme (WFP) which are directly concerned. 40 per cent of the population living in the refugee villages are children under the age of twelve. In addition, the refugees brought some 3 million livestock now grazing on Pakistani land. Although the physical environment in which many of the refugees now find themselves is often very different from that they were used to in Afghanistan, many of them are trying to settle down where they are with the consent of the Pakistani Government. Where a certain degree of permanency is thus felt, and the refugee community is on government land, the building of traditional *kacha* (mud) huts is encouraged, as it is preferable from a health point of view to living in tents, especially in winter. Refugee villages - there are at least 100 of them - are often spread out over many miles. Although this reduces the problem of overcrowding and epidemics due to promiscuity, it causes administrative problems in the equitable distribution of aid.

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The health of the refugees

The needs of refugee communities are the same all over the world: water, sanitation, food, and health care. The Pakistani Government's efforts to ensure that the refugees remain healthy are impressive. The Government's plans are to provide access to health care to every refugee community of 5000 to 10 000 people, combined with the provision of adequate quantities of safe water, safe excreta and refuse disposal, adequate housing, a culturally acceptable balanced diet, and the prevention and control of communicable diseases. In fact, what the Government is endeavouring to provide is the basics of a primary health care (PHC) programme, the more so as major health and diseases problems of the refugees are also those of the local population.

Nutrition

From a visual impression, the overall nutritional status of the refugees seems to be good, although wheat has mostly been the only commodity delivered for the past three to six months and infectious diseases are common. Malnutrition is not really obvious, even among women and children. The practice is to give 15 kilos of wheat, two pounds of oil and dried skimmed milk, one-and-a-half pound of sugar and 90 gms tea to everyone per month. Infant formula food is distributed as a gift -- but the instructions on the tins on how to prepare it are written in Portuguese! The dangers of infection associated with this type of food, especially when used with baby feeding bottles in such poverty-stricken circumstances, are well-known by now. The finding of a 1.6 per cent rate of xerophthalmia (vitamin A deficiency) -- a disease which may lead to blindness -- amongst a sample of refugee children could be remedied by a mass distribution of vitamin A capsules.

The very notion of primary health care (PHC) indicates that the treatment of mild malnutrition should preferably be done at the village dispensaries - when and where they exist - rather than cases referred to hospitals. It has been proven in many relief operations that this is feasible, and is culturally and socially preferable for the family and affected child. Each dispensary or rural health unit therefore needs a small supply of dried skimmed milk, oil and sugar, to be used for the treatment of mild or moderate cases of malnutrition.

Sanitation

Many of the important infectious diseases from which the refugees are suffering are related to insanitary environmental conditions. More "ideal" latrines should therefore be built in the villages, especially, where schools exist, by the schoolchildren under supervision, so that the refugees can see them and talk about possibly having their own. Every encouragement should be given for each family to have its own latrine.

Control of communicable diseases

WHO is helping to implement tuberculosis and malaria control programmes, and an expanded programme of immunization (EPI). There is need for more active case-finding of those suffering from tuberculosis, and for improvement of follow-up of individual patients who have a tendency to stop and re-start treatment. Problems have been experienced in obtaining spraying equipment and laboratory diagnosis in the prevention and control of malaria.

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The efficacy of any EPI programme, especially for the distribution of a second and third round of DPT and polio vaccines, are a worldwide problem and not peculiar to refugee communities. Community participation and the use of more women in the vaccination teams might improve the attendance rate. As everywhere, logistics are a problem for both staff and for maintaining the cold chain.

Maternal and child health (MCH)

As many of the health and disease problems are to be found amongst women and children, a simple form of an MCH programme with particular emphasis on home visiting could help reduce the illnesses and deaths seen in this "at risk" group. Much care for women is provided by the Afghani traditional midwife.

Since all refugees have access to any level of health care provided by the Government, this has resulted in most of the district hospitals being flooded with refugees, sometimes to the resentment of the local population, whereas the refugees often have simple problems that can and should be dealt with at primary health care level. Dispensaries might thus help partially solve this problem by improvements in drug supply, equipment and type of care, some of them suffering from lack of basic drug supplies and equipment.

Health education

There is very little health education in practice among the refugees. Although this is probably one of the most difficult aspects of health care to implement, the health staff at the basic health units need to spend more time to educate the community on subjects relevant to the main health and disease problems.

Training

A Government sponsored village health worker training programme having been and still being in operation in some areas of Afghanistan, therefore to try to start a similar type of programme among the refugees, perhaps on a more simple scale, may not come as particularly new to some of refugees. It would be very important to try and train women, especially the *dayas* (traditional midwives). In this context, a particular recommendation of the WHO consultant is to implement a Community Health Worker training programme in the refugee communities, using their own people, perhaps after a study is undertaken of the role, beliefs, and practices of the refugee women regarding health and the attitudes of the mullahs, maleks and tribal leaders. According to the WHO consultant's own words: "Primary health care can only be successfully implemented if the health staff get out into the community and work with the refugees on the priority problems. All the health staff, and particularly the health visitors and midwives, should therefore spend less time in the dispensary handing out pills and more time advising women in their own homes".

WHO collaboration

During 1981, WHO provided technical assistance to UNHCR and other UN agencies on sanitation, immunization, control of communicable diseases, essential drugs, malaria, tuberculosis, eye diseases, etc. WHO medical officers and consultants visited refugee camps and villages, conducting surveys and assessing the health situation.

A few examples:

-- Malaria is more widespread among refugees than among the local population. A plan for the control of the disease was therefore prepared with the purpose of strengthening malaria services with 150 additional staff, transport facilities, providing insecticides and anti-malaria drugs.

-- Ambulatory treatment of tuberculosis has now been introduced in dispensaries located in refugee villages, in addition to existing rural health centres and hospitals.

-- Children are being immunized. The plan for increasing EPI staff in both provinces also made provision for the vaccination of half-a-million children and 200 000 pregnant women.

-- A high percentage (nearly 40%) of children having been found suffering from trachoma by a WHO specialist, UNICEF promptly delivered a sufficient quantity of antibiotics for eye treatment, in addition to vitamin A distributed to a few children affected by xerophthalmia.

-- Sufficient amounts of oral rehydration salts (ORS) for the treatment of diarrhoeas was also provided by UNICEF at WHO's instigation.

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RURAL WATER SUPPLY IN THE YEMEN ARAB REPUBLIC

The development of rural water supplies is considered by the Government of the Yemen Arab Republic as a key asset for the improvement of the quality of life in rural areas. Although 89 per cent of the country's population of 8.5 million is rural, only 18 per cent of these have easy access to safe drinking water.

A major obstacle to the development of water supplies in rural areas of Yemen is the extremely high cost of construction. In fact, most villages and other human settlements are located on mountain tops whereas groundwater is naturally in the valleys. Therefore, the operation which consists of raising the water to the level of the consumers is much more costly in Yemen as compared with other countries where water and people are at about the same level. It has thus been estimated that nothing short of US$ 400 million would be necessary to completely equip the country's rural areas with water supplies in order to meet the requirements of the International Drinking Water Supply and Sanitation Decade (IDWSSD).

Facts and figures

In 1976, the Government of the Yemen Arab Republic launched a five-year (1976-1981) National Development Plan. Expenditures for rural water supplies during this period were in order of YAR rials 170 million or US$ 38 million, of which 33 per cent were financed by the Government and the remaining 67 per cent from other local and foreign sources. It is in this context that WHO and UNDP provided technical services in support of rural water supply projects.

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The first National Development Plan is now over and the Rural Water Supply Department has implemented a number of projects with WHO/UNDP technical and financial cooperation. From 1976 to 1981, a total of 147 projects have been carried out by the Government, complete with wells, tanks, pump houses and pipelines. Another 145 projects have helped improve existing water resources, 115 wells have been drilled. This represents a significant achievement of the 5-year plan. All in all, 300 000 people in rural areas have benefited from the water supply programme during this period.

The future

WHO project staff have assisted the Rural Water Supply Department in the preparation of the second five-year (1981-1986) development plan under a UNDP funded cooperation project. All parties concerned have agreed to extend the project into a new 5-year phase (1982-1986). The new project puts emphasis on strengthening the Department's technical and administrative capabilities and on training staff which the country so badly needs. Cooperation will continue in the fields of investigations and surveys, planning, design, supervision of construction, and operation, maintenance and repair of water supplies, in an attempt to meet the goals of the International Drinking Water Supply and Sanitation Decade in Yemen.

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PRINCE KARIM AGA KHAN ON PRIMARY HEALTH CARE

Talking informally with Pakistani and foreign newsmen in Karachi on the occasion of an international conference on the Role of Hospitals in Primary Health Care jointly sponsored by the Government of Pakistan, the Canadian International Development Agency, the Aga Khan Foundation and WHO, Prince Karim Aga Khan called for a systematic motivational campaign to galvanize rural populations in favour of primary health care in order to remove the great disparity in the quality of life between rural and urban areas. He said he was confident that the response from village to village would be tremendous and that rural community participation would help produce really positive results in the vital sector of primary health care. Pointing to capital-intensive institutions like major hospitals, Prince Karim said that they could play a dominant role in promoting primary health care.

Seated beside him was Dr Halfdan Mahler, Director General of the World Health Organization, who also participated in the question-answer session. Dr Mahler spoke against what he termed bureau-technocracy which has made the problem of primary health care an object of manipulations and emphasized that the programme for its success had to be people-oriented. He said that hospitals having the technically competent and socially motivated staff could become a decisive partner in primary health care.

(from "DAWN", Karachi, November 1981)

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