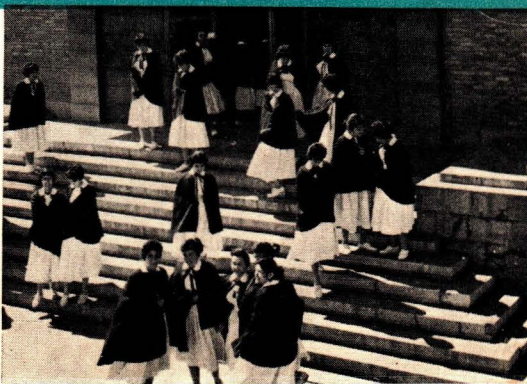


annual  
report  
of the director  
to the regional  
committee  
1961-62

REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN



WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN

ANNUAL REPORT  
of the  
REGIONAL DIRECTOR  
to the  
TWELFTH SESSION OF THE REGIONAL COMMITTEE

1 July 1961 - 30 June 1962

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I N T R O D U C T I O N

## I N T R O D U C T I O N

Before considering the salient points of the Regional programme and reporting on activities, I should like to express my deep appreciation to Governments of Member States for their splendid cooperation with the Regional Office during my first term as Director, and once more to extend my personal thanks to them for their confidence and support.

\* \* \*

It may be of interest at this time not only to report on happenings during the last twelve months but also to consider the future in the light of past experience. In doing so I believe it would be appropriate to confine the vista to the next five years in relation to developments since 1957. Such a review should reveal the strength and weakness of health plans and programmes in the Region. It could also determine the extent to which the Organization has been fulfilling its Constitutional obligations, particularly in assisting Governments "upon request, in strengthening health services", stimulating and advancing work "to eradicate epidemic, endemic and other diseases", and in promoting "improved standards of teaching and training in the health, medical and related professions". These, together with a continued evaluation of health plans and achievements, are considered to be the most important functions of the Organization in this Region, and to make clear the scope and limitations of the resources available for performing these functions should also lead to the best possible benefit being derived from WHO assistance.

\* \* \*

It is a gratifying experience to be able to look back at our activities in the wider setting of the whole economic and social developments in the Region. Considerable progress has been achieved in these fields and it is encouraging to note that almost all countries are giving due place to health as an integral part of their overall development plans. In their desire for the health of their people to be rapidly improved, Governments are more often availing themselves of WHO assistance not only for direct technical aid but also, and to a large extent, for coordination of the assistance provided by other international or bilateral bodies. This coordinating role of WHO at field level is growing in importance with the broadening and deepening of the stream of assistance going into the Region, especially to the countries economically less fortunate, or less advanced in the field of health. This has necessitated the gradual strengthening of WHO advisory and representative services in a number of countries of the Region.

\* \* \*

Our cooperation with the United Nations and international or bilateral agencies working in fields related to health has been and continues to be close and fruitful. I would like to draw the attention of the health authorities to some recent developments within the United Nations family, which have important impacts on the future health and socio-economic developments in the Region. I have in mind the resolution of the United Nations General Assembly last year on the Development Decade, as well as the creation of the United Nations Special Fund and the International Development Association.

\* \* \*

The United Nations General Assembly at its 1961 session, adopted a resolution\* designating the current decade as the Development Decade in which States Members of the United Nations or Members of the specialized agencies would intensify their efforts to accelerate progress in the growth of the economy and in their social advancement. It was emphasized that each individual country should determine its own specific objectives preferably embodied in a comprehensive development plan.

The Fifteenth World Health Assembly last May endorsed\* the Executive Board's recommendation that, in so far as the health aspects of accelerated economic and social development were concerned, Governments should participate in programmes envisaged in the Development Decade resolution, with the assistance of WHO if they so wished, by undertaking a ten-year public health programme with certain specific objectives to raise the standards of the health of the people. The Regional Office would be willing to assist countries in the formulation or revision of such programmes, and WHO team surveys and technical assistance might be envisaged.

Needless to say there is a direct relationship between economic, social and health factors, and if the Development Decade is to witness a balanced development, health must have a high place in the list of targets which nations will establish for the improvement of their peoples' lot.

\* \* \*

The United Nations Special Fund has been concentrating its activities in three fields: pre-investment work, especially surveys and feasibility studies of natural resources, technical and vocational training, and the establishment of institutions for applied research.

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\* See Annex I

The emphasis in selection of projects has been on those which are expected to accelerate the economic development of the developing countries, although it is now being increasingly recognized that the sector of "human resources" is essential in economic development and that to have a lasting effect it is necessary to have balanced economic and social progress.

The Special Fund has been approving and assisting a large number of training projects - some concerned with teacher training, some dealing with technical and vocational training, and others in various fields of agriculture, forestry, telecommunications, etc. There appears to be good reason to expect that medical training institutions could be included in this programme, especially for countries which entirely lack such training institutions and for whom building-up of the health potential and up-lifting the production capacity of their human resources is vital for their balanced economic and social advancement. The pre-investment phase of such a project would usually be the responsibility of WHO personnel, and the Special Fund could contribute towards the establishment of the medical training centre - or to the capital investment phase.

The Regional Office would be prepared to help countries in their selection of projects and in drawing up their submissions in acceptable form. Also, in the subsequent stage, advice could be given to Governments in the planning and formulation of requests to bring them into line with the established criteria of the Special Fund. Collaboration and advice would also be solicited, as required, from the country directors of the Special Fund, who are also Resident Representatives of the Technical Assistance Board.

\* \* \*

The International Development Association (IDA) is an affiliate of the International Bank for Reconstruction and Development and is administered by the Bank. It came into being in September 1960 and started effective work last year. The purpose of IDA is to provide external development capital to countries which, for balance of payment reasons, are unable to raise sufficient funds abroad on conventional terms. It thus helps to promote economic development and so raise living standards in its member countries by giving long-term loans with very low interest charges or no interest at all, and payable in local currency. IDA may give loans for a wide range of projects, including not only directly productive schemes such as are normally financed by the Bank, but also for projects of a social character. For example, the Association is authorized to finance any project which is of high development priority whether or not the project is revenue-producing or directly productive. Thus, projects such as water supply, sanitation, pilot housing, etc., are eligible for financing although it is expected that a major portion of IDA's allocations would be for directly productive projects. IDA might also consider the financing of building construction for education and training projects.

In this Region, IDA extended its first development credit to Jordan last year in an amount of \$2 million to finance the expansion and improvement of the water supply system in Amman. The total cost of the project is estimated at the equivalent of \$3 million, and the IDA credit is being extended to the Jordan Government for repayment over a period of fifty years including a ten-year period of grace.

\* \* \*

So much for some of the new resources potentially available for the development of health programmes. I should now like to refer to some highlights of our activities in the Region, and it occurred to me, as mentioned before, that in these introductory remarks it might be worth while to touch upon some of the points connected with our operations in the last five years with a forecast of future trends. In reviewing our work it is important to explain that the order of presentation does not imply in any way an order of priority, since the different countries of the Region represent differing levels of health organization and widely differing standards of social and economic background, so that what is a priority for one may not be so for the other. It is therefore important that the programme of this Office be viewed in the wider collective sense.

\* \* \*

The education and training of professional and auxiliary personnel will remain for a long time one of the most important aspects of the Organization's programme. A clear illustration of the needs in this Region with its twenty-five countries and territories and 210 million people is the population/doctor ratio. In four countries only is the ratio better than 2,500, and these countries represent only 2.5% of the Regional population. In three other countries, where about 25% of the people of the Region live, the population/doctor ratio is between 2,500 and 5,000, in four others, representing 10% of the population, it ranges from 5,000 to 10,000 and in the remaining countries where about two-thirds of the people live, it is above 10,000, in one case being as high as 150,000 inhabitants per doctor.

To remedy this situation, both short-term and long-term plans are necessary. In the past few years, with the aim of

bringing immediate relief to a number of countries faced with problems of disease control and lack of basic health services, the concentration has been largely on training auxiliary personnel, although assistance in medical education has also been requested and given. Now the picture is changing and during the next five years it is expected that medical education will be emphasized to a greater extent.

Assistance in the training of sub-professional and auxiliary personnel during the last five years has been given through thirty-three country projects with an approximate number of eighty posts filled by international staff, and comparatively quick results have been obtained. By this time, most countries of the Region have developed their own institutions for the training of nurses and auxiliary personnel, and greater attention will therefore be devoted in future to inter-country training projects, with the object of supplying supervisors and tutors for the various categories of health workers required.

During the same five-year period, a total of 1141 fellowships were awarded, of which 166 were for medical education and clinical basic medical sciences, and 72 for undergraduate medical education to countries with no medical schools. Consultants and visiting professors have also been sent to assist at various medical schools and to supplement their faculties. From 1957 to 1961, twenty-four medical educationalists, many of international repute, made studies, advised and worked in the medical schools of some of the countries of the Region. An analytical study based on their detailed reports and specific suggestions for improving the institutions they visited, has recently been prepared by a Special Consultant on Medical Education, and this should help in the future development of medical schools in the Region.

Out of the twenty-seven medical schools in eight countries of the Region, two-thirds came into being during the past two decades. It is, however, expected that the next five years will be a period of real development of medical education in the Region, especially in countries hitherto without it. Our aim is to continue assistance for improving the standard of the present schools and also to help in planning and establishing new medical schools.

A Regional Conference on Medical Education is to take place in Teheran in October. Regional countries with their rich heritage of medical sciences in the past have many common cultural, public health and social features, and are responsive to new ideas and methods in the educational field. It is expected that this Conference through disseminating a wider knowledge of modern trends resulting from scientific progress in all disciplines of medicine, will help to give the required guidance in medical education. In addition, it is proposed that our Regional Advisory Services for medical education be strengthened to meet this pressing requirement.

\* \* \*

Five years ago malaria eradication programmes were underway only in six countries of the Region, now all the countries are undertaking measures for eradication, and in Iraq, Israel, Jordan, Lebanon and the Syrian Arab Republic, the last stages are being approached. At the end of the next five-year period it is expected that the disease will have been eradicated also from Iran, and eradication will be at an advanced stage in Pakistan, Saudi Arabia and the United Arab Republic.

As success in eradicating malaria, which has become one of the major social urges of the age, depends on the technical

proficiency and administrative ability of the staff employed to do the work, stress is placed on training activities. Two WHO-assisted training centres are already operating in Pakistan, and there is one in Ethiopia. This year it is expected that one will be established in Saudi Arabia and another in the Sudan. These centres, together with those in Teheran and Cairo provide courses for both professional and sub-professional personnel in accordance with the standards established by WHO. Fellowships are also awarded to instructors in these training centres as well as to senior personnel to attend international courses abroad, or to visit advanced programmes under the scheme for exchange of scientific workers. In addition, the Regional Office is ever ready to provide, as it has done in the past, advisory services to Governments both in the training as well as in the operational aspects.

Eradication of malaria goes through phases including preparatory, attack, consolidation and maintenance. Although the two first phases, namely preparatory and attack, can be conducted with an autonomous service, the consolidation phase will prove most defective and expensive unless all public health institutions in the country, hospitals and dispensaries, collaborate in detecting and notifying all malaria cases. This is the crucial phase when the incidence of malaria is very low, when Governments begin to lose interest in malaria eradication as a priority programme that needs continued financial support to finish the hard job of eliminating the last foci of a disappearing disease. Here also the public health structure of the country undergoes a severe test. Unless this structure correspondingly expands its peripheral rural units on a total coverage basis in the areas being cleared of malaria, and unless it is realized that the responsibility of maintaining

freedom from malaria will fall fully on this structure during the maintenance phase, and that all its staff must be prepared to participate in this programme during the consolidation phase, the efforts and the millions of dollars spent on these programmes would not be justified. The Governments' recent drive to expand their basic rural health services and to make them participate in the malaria eradication activities, constitutes one of the greatest collateral benefits derived from their experience in conducting such disease eradication programmes.

The Regional Office is maintaining its coordination and cooperation in the field of malaria eradication, both with UNICEF and US AID. In addition to this, neighbouring Governments have been stimulated to negotiate bilateral agreements to enable malaria workers to meet periodically and coordinate their activities in border areas. Such agreements have been put into effect between Iran and Iraq, Sudan and Ethiopia, as well as Saudi Arabia and Yemen. Pakistan has participated for the second time in the Indo/Burma border meeting. Another example of inter-regional coordination was demonstrated by the Inter-Regional Technical Meeting on Malaria Eradication which was held in Teheran in May 1962. Afghanistan, India, Iran, Iraq, Pakistan, Syrian Arab Republic, Turkey and USSR participated at this meeting where technical problems, mass nomadic movements, and the importance of rural health were discussed.

It is heartening to note the response of every country of this Region in issuing postage stamps on malaria eradication, and their donation of a percentage of the sales proceeds or a number of stamps for the benefit of the Malaria Eradication Special Account. This response reflects the interest and importance given to malaria eradication in the health programmes of the Region.

\* \* \*

In the field of tuberculosis control, the policy adopted by the Organization involves continued training of specialized and general health services personnel for carrying out tuberculosis control work, and this is assuming greater importance with the concept of integrating simple tuberculosis control procedures into the routine of general public health workers. It is also advocated that the present technical knowledge in tuberculosis control be more widely applied, but developed locally, tested and evaluated in a pilot area, and the optimum operational conditions adopted for expansion. The Organization has also given approval to the use of freeze-dried BCG vaccine. This will solve the difficulty in tropical climates of maintaining liquid BCG vaccine at sufficiently low temperature to ensure potency. All Ministries of Health have been informed and pertinent information supplied. These decisions for tuberculosis control have stimulated Governments to review their own tuberculosis control programmes for the purpose of using their available facilities more effectively and ascertaining where WHO and UNICEF might be of assistance.

\* \* \*

Endemic foci of smallpox still exist in a number of areas in the Region. Several countries have launched or have decided to embark on smallpox eradication campaigns. Some success has already been achieved in certain areas and the results so far are encouraging, but we should not be over-optimistic, as the problem still demands great consideration and care.

The availability of lyophilized dried smallpox vaccine has solved the great difficulty of transporting vaccine to remote areas without its potency being affected, but in spite of this and the measures taken by the Governments to improve the

organization and execution of their campaigns, results have not reached expectations.

Quarantine centres for isolating infected or suspected cases of smallpox, surveillance as a procedure for the detection of imported cases, the imposition of vaccination only when the disease might gain a footing in the country; these measures do not guarantee that smallpox will not be introduced. Safety is only secured if a high immunization index of the population as a result of mass vaccinations and revaccinations is maintained.

WHO, realizing the importance of the problem in the Region and in the world, is prepared to assist to the fullest possible extent with the eradication programme. It is hoped that with intensification of the campaigns, this disease will come under effective control in the near future.

\* \* \*

With regard to the bilharziasis problem, a comprehensive plan of action including training, research, surveys and control is being considered for the whole Region. It is believed that with the concerted efforts of Governments, WHO and UNICEF, it may be possible to eradicate the disease in certain isolated areas and control it in others where it is widely spread. Concomitant with the intensive field research work being developed at the Bilharziasis Control Pilot Project and Training Centre in Kafr El Dawar, United Arab Republic, the training of professional and auxiliary personnel in the various phases of the work is being undertaken. Most of the developing countries of this Region have comprehensive plans for extension of irrigation and agriculture and this carries with it potential dangers for the spread of bilharziasis. It has therefore become a race against time to find an effective measure for its control.

\* \* \*

There is no doubt that mental health is actually an important problem in this Region, and is expected to become increasingly so. The popular view that psychiatric disturbances are rare in certain traditional cultures, still elementary in the evolutionary sense, dies hard. This view is incorrect and misleading. It may lull both the public and the authorities into complacency and a false sense of security. It may even fail to inspire and motivate efforts towards the protection and promotion of health.

There are two factors which are responsible for this impression. (1) At the present level of development, the concept of health and of disease in some countries is still evolutionally indistinct and non-specific and in consequence some diseases are still regarded as belonging to other institutions such as religion or magic. This is our experience in relation to involuntary melancholia and simple depression. Many of these cases are beginning to be conceived correctly as education of the public gains more influence. (2) The question of the threshold level of members of a society tends to determine the level of susceptibility to psychogenic factors, i.e. factors which may precipitate neurosis. Community development tends to lead to self-discovery as a result of education and sophistication. As this is associated with a lowering of the threshold to psychogenic experience it follows that the more the community is developed socially and culturally, the lower this threshold becomes. This explains the rising index of neurosis in the West and in North America. It portends the increasing importance of mental health problems in the future. There is yet another reason why mental health should become increasingly important in the future in this Region. Tensions and stresses arising from the impact of processes of change are likely to

impulse behavioural trends and instabilities not necessarily specific to health. The expression may be largely social in the wider sense of the term. In this respect it should be strongly emphasized that the role of health education during this period of rapid change and evolution is significant. Health education if stressing only disease and symptoms complex rather than health and its positive quality, may lead to the establishment of these early tensions as firm neuroses. Many of these tensions are healthy and physiological reactions to changing cultural conditions, and are particularly susceptible to health education.

I should also mention that health should not be conceived as separate and distinct from the social and economic processes or from the community it serves. Indeed, it follows the community as a shadow. Health is no longer to be viewed within the confines of what is strictly medical. The subject of health is the community in action in the widest dimensions of time and space. Thus community development becomes an integral part of the promotion of health and the promotion of health becomes itself a function of the community. In fact, in order to promote medicine, the community should be promoted. To represent medicine as a commodity, and society as a consumer, and to work this out in the mirage of economics is to misunderstand the whole thing.

\* \* \*

As regards the policy and activities in the field of maternal and child health, it would be well to emphasize here that some changes in the concept of paediatric education and paediatric practice are required in most of the countries of this Region. Quantitative needs are also great and expansion should keep pace with qualitative improvement.

To be fully effective a paediatric service should be a child health service integrating curative, preventive, and social activities of hospital (including out-patient department), clinics, centres and the homes into one organization utilizing wherever possible the same physical facilities and the same personnel. The present division into "Paediatrics", "MCH", "Well-baby clinics", "Home care service", etc., is wasteful and less effective in reducing infant and child mortality and morbidity than the well integrated child health service.

The prevalence of malnutrition particularly of mothers and pre-school children makes the study of nutrition in both urban and rural areas imperative. Cheap, acceptable and nourishing local foodstuffs (as Incaperina produced by "Incap", Guatemala) must be found, and the people encouraged to use them. It is recommended for this purpose that country-wide applied nutrition programmes with local adaptations of a few simple practices most urgently in need of improvement should be undertaken. A central nutrition unit should be established in the Ministry of Health to direct the programme, and ensure that proper training is given to workers in all walks of life who are in contact with the people and are thus able to pass on the knowledge of nutrition they have acquired to those who need it most.

\* \* \*

In the field of cancer control and radiation protection, our assistance to the countries is continuing to grow. It is planned to provide far more expert advisory services and also to award more fellowships for specialized training. A regional training centre for cancer control activity is being planned.

\* \* \*

The very limited availability of reliable vital and health statistical data remains a barrier for efficiently measuring health problems and health progress. The inadequacy of health statistical services is a signal weakness in the general health services of most of the countries in the Region.

However, the need for accurate health statistics is being increasingly felt by the Governments, and with more health personnel in the various categories becoming available, a progressive improvement in this field may be foreseen.

The Regional Office is planning to strengthen its advisory services in statistics. Training of statistical personnel will be maintained and expanded as far as resources permit. As another measure for developing health statistics in the Region, a group meeting on vital and health statistics is being prepared for 1963.

\* \* \*

Now a brief reference to the flood disaster which occurred in Somalia towards the end of 1961, and which affected about a quarter of the country and about 600,000 people. Thanks to the concentrated action of friendly Governments, the League of Red Cross Societies, the World Health Organization, and other agencies of the United Nations, the dangers of epidemics and famine were largely averted. Nearly a million dollars worth of emergency medical supplies and drugs were donated, as medical relief. WHO Headquarters, Regional Office and field staff, in their respective spheres, assisted with the establishment of emergency medical stores, distribution of the medicaments and supplies, in surveying the nutrition situation, and particularly in coordinating the overall health and relief work and making recommendations for future action.

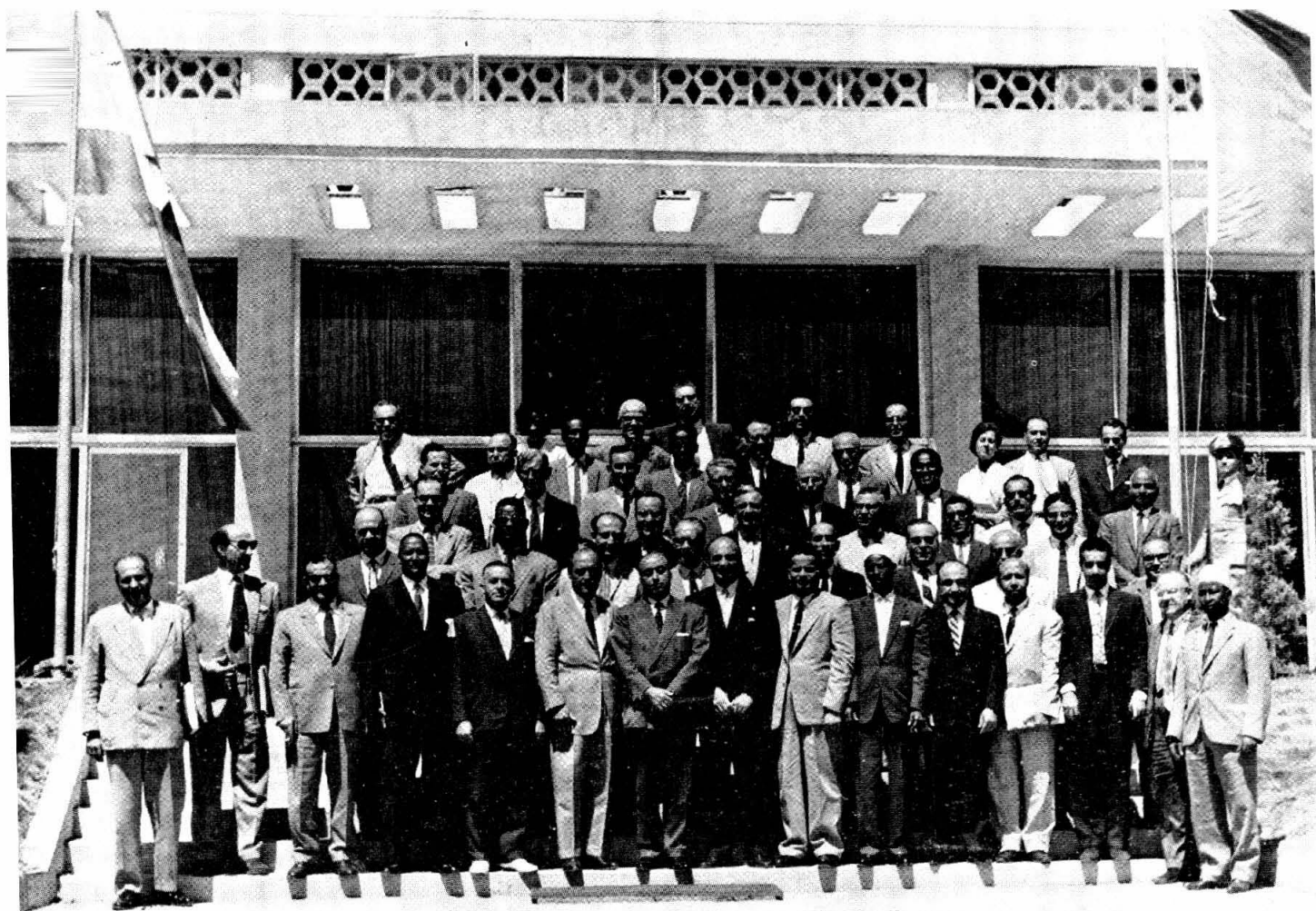
\* \* \*

The Somalia operation is a golden example of what can be accomplished through concerted effort. There are many others which, though less spectacular, are equally important. In concluding these introductory remarks, may I reiterate my sincere thanks to the Governments of the Region for their generous collaboration and support which has led to the successes we have achieved, and in so doing quote an ancient Arabic saying which has its parallel in most other languages:

Spears grouped together will stand and prevail  
Whilst one, unsupported, may falter and fail.

## ELEVENTH SESSION OF THE WHO REGIONAL COMMITTEE (SUB-COMMITTEE A)

Seventeen governments, the United Nations and several of its subsidiary bodies, the Arab League and a number of non-governmental organizations, were represented at the meeting of Sub-Committee A of the WHO Regional Committee for the Eastern Mediterranean, which was held from 28 August to 1 September 1961, in Chtaura, Lebanon.



Representatives at the 1961 Session in Chtaura of Sub-Committee A of the WHO Regional Committee for the Eastern Mediterranean.



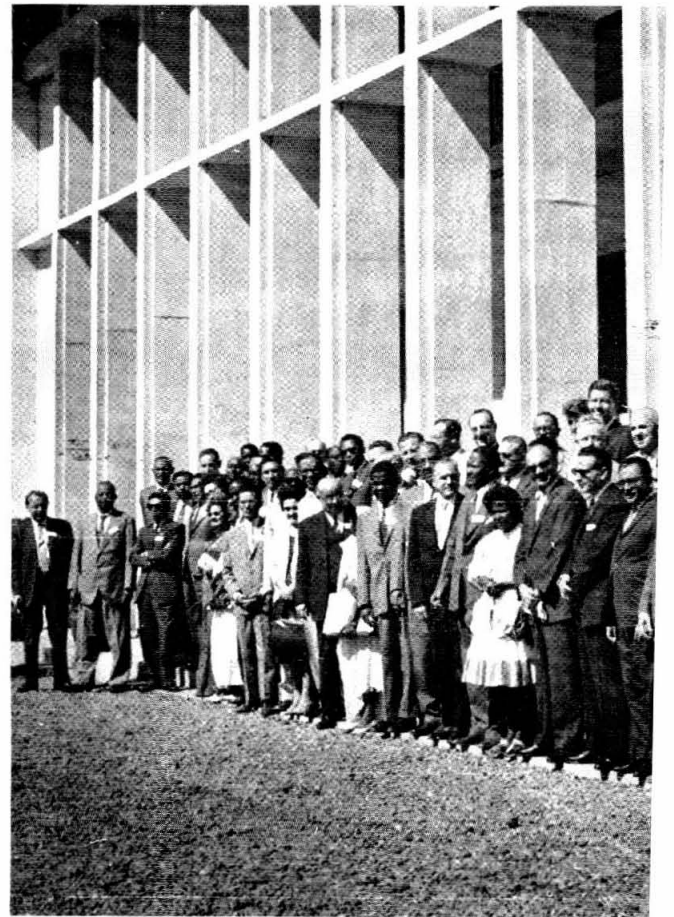
CYPRUS : Dr. M.G. Candau, WHO Director-General, and Dr. A.H. Taba, Regional Director, were received by Archbishop Makarios, President of Cyprus, during their visit to that country, last spring.



IRAN : A new grad of Nursing (Teheran) IHM Empress Fara



PAKISTAN: Gen. W.A Burki, Minister of Health, Labour and Social Welfare (Pakistan), opened the Water Works Operation Course convened in Lahore, under WHO sponsorship, from 18 September to 11 October 1961.



SUDAN : A group of participants and observers from Conference on the Training of Auxiliary Health Perso

## EVENTS OF THE YEAR



Reza Shah School promotion pin from



UAR : A graduate student from the Higher Institute of Nursing (Alexandria) is congratulated by Dr. Abd El Aziz El-Sayed, Minister of Higher Education (UAR), formerly Rector of Alexandria University.



SAUDI ARABIA : A graduate from the Health Assistants' and Sanitarians' Institute (Riyad), is handed his diploma by H.E. Dr. Hamed Harsani, Minister of Health of Saudi Arabia.



WHO's six Regions at the Inter-Regional Meeting in Khartoum, from 14 to 20 December.

The opening address was given by the late Dr. Mohammed Ahmed Aly, Minister of Health (Sudan)

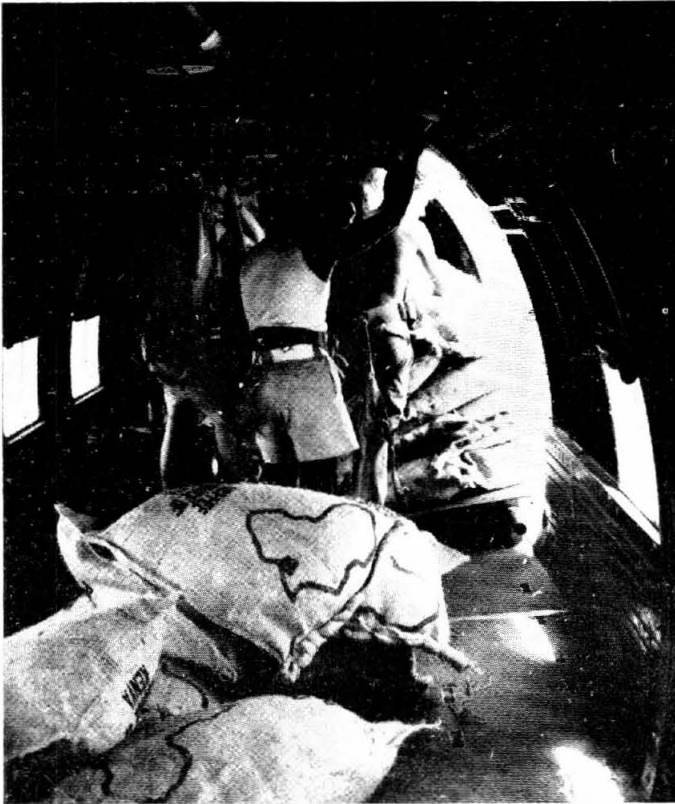


SOMALIA : One of the 11 public health assistant nurse midwives who graduated early this year in Mogadishu, is congratulated by H.E. Dr. Abderashid Ali Shermarke, Prime Minister of Somalia.



Last fall's heavy floods affected the main food-producing areas of Somalia — up to one fourth of the young Republic's territory.

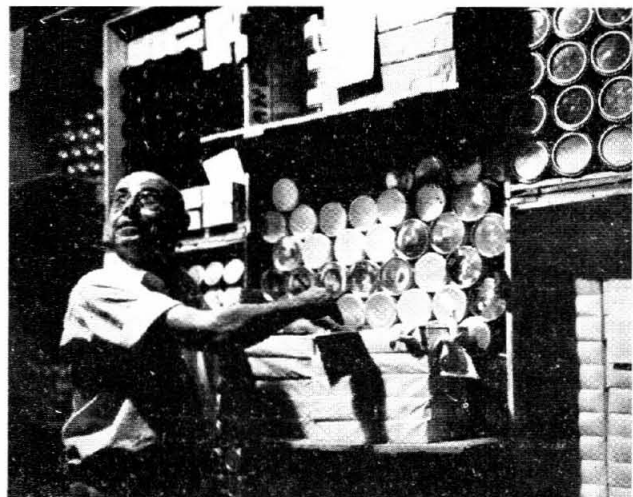
## EMERGENCY ASSISTANCE TO FLOOD-STRICKEN SOMALIA



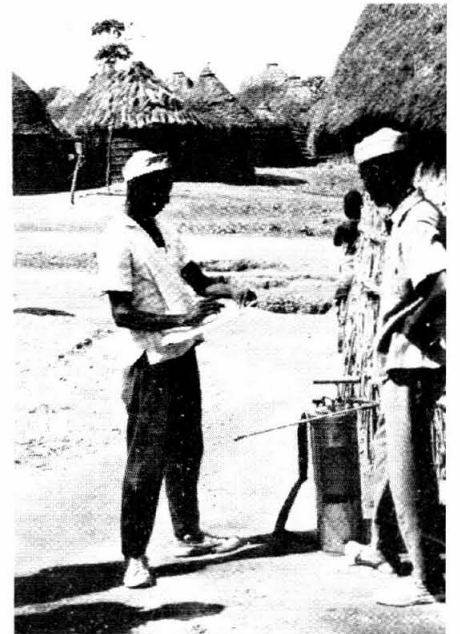
Pushing another load of maize through the open door of a Valetta.

About one million dollars worth of drugs were rushed to food-stricken Somalia last fall. Emergency assistance to check epidemics came in from ten countries, including Ethiopia, Kuwait, Sudan and the United Arab Republic.

With a saw, a hammer and the extra-professional help of WHO advisers, empty packing cases were converted into shelves, making possible the issue and control of the hundreds of items of donated medical supplies flown to Mogadishu.



Preparing to spray more huts in one of the 1,000 villages at risk, to stop in their track flood-borne malaria epidemics.



G E N E R A L R E V I E W

I THE REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN  
ELEVENTH SESSION

1. Sub-Committee A of the Regional Committee met in Ohtaura, Lebanon, from 28 August to 1 September, and Sub-Committee B in Geneva on 21 and 22 August 1961.
2. During discussions on the Annual Report of the Regional Director, it was reported that national budgets for health were increasing satisfactorily and the majority of the countries of the Region were expanding their health programmes. Progress had also been made in most countries in their malaria eradication activities, but the importance of improving inter-country co-ordination in this and all fields was stressed.
3. Research in communicable diseases and new fields of endeavour such as virology, radiation protection and mental health was considered essential and assistance from the Organization continued to be needed for this purpose and the control particularly of tuberculosis, smallpox, bilharziasis, communicable eye diseases, venereal diseases, cholera and favus.
4. In expressing approval of the expanding education and training programme and particularly the increased number of fellowships, the planning of regional training projects in new fields was urged. In pointing out the necessity for continued assistance in filling the need for all categories of personnel, the training of nurses and auxiliaries and of mental health workers, especially of psychiatric nurses, was particularly mentioned as well as the staffing with adequately trained personnel of the rural health centres which were growing in number and being decentralized. The importance of the rural health and environmental sanitation aspects of community development was recognized. It was observed that the mortality rate amongst young children in the Region, especially in rural areas, remained high and this was one reason why in expanding activities in the field of nutrition, mothers and children should be given special consideration. By the continued evaluation of all projects and programmes many of the administrative

and technical difficulties hitherto encountered could be avoided and thus maximum success might be obtained.

5. In endorsing the Proposed Programme and Budget Estimates for 1963 for transmission to the Director-General, appreciation was expressed of the increased provision made for projects in the new fields mentioned above, as well as in others such as community water supply. Member States were urged to increase their efforts in the establishment and development of national radiation protection programmes. The importance of inter-country coordination in all fields was again stressed.

6. Specific technical papers discussed were: malaria eradication, smallpox control and eradication, problems of cancer, hospital administration, rural health, the management of medical stores and pharmacy as part of public health administration, and khat.

7. Technical Discussions were held in both Sub-Committees on poliomyelitis, for which papers had been submitted from experts abroad as well as in the Region. The importance of promoting assistance and reporting poliomyelitis in countries of the Region was reiterated, and it was recommended that well organized virological and serological services should be established before any mass vaccination campaigns, using live attenuated poliovirus vaccines, were embarked upon. It was also recommended that where inactivated vaccine for the immunization of infants and young children had been introduced, this should continue to be used until it was possible to shift to the live attenuated poliovirus vaccine.

8. "Hospital Administration" was chosen by Sub-Committee A for their Technical Discussions in 1963. (Both Sub-Committees had decided previously that "Solar Radiation and its Related Heat Effects on the Human Organism" should be the subject for the Discussions at the Twelfth Session in 1962).

## II ADVISORY AND TECHNICAL SERVICES

### EDUCATION AND TRAINING

#### GENERAL

9. Although with few exceptions, the economic and social conditions of countries of the Region are fundamentally the same, there is a marked difference in resources, educational facilities and availability of trained personnel.

10. Thus, in analyzing past programmes, present projects and future plans in the field of education and training, there are no general criteria to follow for all countries of the Region and they will therefore be grouped roughly into three categories according to their circumstances. This may mean of course that full justice is not always given to a particular situation, but this is part of the nature of abstracting facts and features in social processes.

11. In the first category are those countries which have academic undergraduate institutions, and in certain cases a variety of postgraduate training facilities. They therefore have at their disposal highly qualified and experienced public health administrators, practising doctors, teachers and large numbers of supervisory personnel, at least in certain professional groups. This particularly applies to the medical profession, whereas training facilities for other professions might not exist, e.g. for nurses. This may account for the highly complex problem of medical care services, particularly in teaching hospitals, a problem which is influenced by numerous factors.

12. In the second category are those countries, which are not yet able to build up and finance their own educational institutions (particularly medical faculties), yet have a rather well developed basic school system with secondary schools and a corps of professional workers educated abroad.

Therefore, medical and health administrators, supervisors, particularly in the medical category, are available, as well as practising doctors and some specialists. It must again be emphasized that wide variations exist in the number of doctors, their age and hence their experience, the number of students studying abroad and the population/doctor ratio.

13. In the third category are those countries which have practically no trained national physicians. There may or may not be a few younger people who have returned after finishing their studies abroad, but in any case they are neither quantitatively nor qualitatively able to play a leading role in the medical and health services of their country.

#### MEDICAL EDUCATION AND ASSISTANCE TO EDUCATIONAL INSTITUTIONS

14. At present there exist twenty-seven medical schools or colleges in the Regional countries. Eighteen of these schools, have been created during the last twenty years. Three more medical schools are expected to be established soon in two countries which already have medical faculties.

15. WHO assistance to the existing medical colleges is limited. However, one project carried out during the period under review should be especially mentioned: a medical education consultative group which, at the invitation of the Government of Iraq, visited Baghdad and Mosul. The group consisted of a Professor of Basic Medical Sciences, a Professor of Clinical Medicine and a Professor of Social and Preventive Medicine. The report is now under discussion and consideration by the national authorities.

16. Assistance in previous years to countries in the first category was mainly in the following forms: visiting professors, teaching missions, individual consultants or consultative groups, and occasional fellowships. Present thinking, and experience with previous projects, show that the emphasis is placed correctly on small WHO consultative groups for individual countries or medical faculties as well as larger inter-country meetings to discuss freely the situation and needs in medical education. This is

certainly more in line with the Organization's policy than to fill a university chair by a foreign professor.

17. The programme for countries in the first category during the next five years will be centred on consultant services in medical education to establish a close link with all medical faculties and colleges, and provide information and advice on the development in the Region as well as elsewhere. It is planned to provide consultants or a permanent medical education adviser in the Regional Office who will prepare and issue to all professors, special information, reports not otherwise available, etc., covering important aspects of medical education.

18. Another plan that it is hoped may be realized during the next five years is for the exchange of qualified professors within the Region so that institutions may benefit from the particular scientific research and teaching experience of highly competent professors. The idea is not only to bring through them knowledge and skills in a narrow specialized field, but to provide an opportunity for colleagues in related fields to exchange ideas and to develop balanced and coordinated programmes of teaching and methods of teaching. Finally, during the next five years the organization of national conferences on medical education will be encouraged as well as the creation of standing curriculum committees or similar bodies keeping a continuous eye on the development of medical education.

19. The assistance in undergraduate medical education to the second category of countries - those with no medical faculties, but an important group of well educated doctors - has up to now largely consisted in giving fellowships for specialized and postgraduate studies to doctors. In one country, Tunisia, one and a half years ago, a medical consultative group made a survey and a report was submitted to the Government, as a guide-line for the future establishment of a medical faculty. Furthermore, since last year, fellowships are being given yearly to two young Tunisian doctors to enable them to be trained and qualified to serve on the teaching staff of the medical school.

20. What is the programme to be recommended for WHO assistance to countries in the second category during the next five years?

(a) Visits and consultations through either consultative groups or a Regional Adviser to study developments in these countries and to keep in touch with the responsible planners. An important point in this respect is the building up of a central hospital as a teaching hospital, to be staffed with sufficient and competent staff, medical and nursing and paramedical.

(b) The preparation of nursing personnel and technicians (laboratory, X-ray, etc.) and librarians. This cannot be sufficiently stressed, and courses are being planned on an intercountry basis for some of these groups of personnel (particularly to prepare tutors and supervisors), so that each country should be able after a certain time to provide itself with competent paramedical staff. It should be emphasized, however, that the first step in this direction should be to turn out a limited number of well qualified persons rather than a large number with a low level of training. This is particularly important in preparing for future teaching activities.

(c) The preparation of academic staff, which should in all cases be supported through fellowships. It is suggested that each of those countries in the second category which are seriously thinking of establishing medical educational institutions should request and be given assistance for a limited period of time for the preparation of staff. In line with experience as well as with the concept of WHO's assistance, priority should be given to the preparation of teachers for basic sciences and social and preventive medicine. However, clinical fields are not excluded.

(d) Material assistance from WHO is rather limited. However, advisory assistance in ordering and installing equipment and supplies, as well as teaching aids will be made available on request. Advice on physical facilities may also be provided and it should be stressed that in the case of hospitals in general and teaching hospitals in particular, the following

should always be consulted: the medical administrator and his staff (particularly nursing staff) on the functional needs; the architect, on the best construction to fill these needs, the engineer to ensure the best installations from a technical point of view.

(e) The internship training of the young doctors which is largely being done abroad should be undertaken as soon as feasible in the social and cultural environment of the student's own country. Adequate hospital facilities, medical and nursing care standards, qualified specialist services and supervision are prerequisites. The forms of assistance mentioned above should be helpful in this respect.

(f) One governmental administrative tool that should not be forgotten, is legislation. The objectives of medical education are helpful in outlining the various types of medical activities which will be the tasks of the doctors. Their rights, obligations, conditions for exercising the profession need to be stated and protected as well as the needs of the public.

21. Countries in the third category, that is, those with practically no medical doctors, still have far to go before they are in a position to think realistically about promoting medical education.

22. It may be pointed out in order to illustrate the diversity of the problem that the population/doctor ratio may not necessarily give a clear picture of the situation. For instance, certain countries in the three separate categories may have nearly the same population/doctor ration and potentially provide equal medical service, yet those same countries differ widely in educational standards and in the use and distribution of their national doctors. Some of these countries may depend entirely on foreign physicians; others may have a fair number of national physicians, but trained abroad.

23. Obviously many other factors enter into play which may be responsible for fundamental differences. From the educational point of view, however, the potentialities of countries in the third category need to be developed

step by step, according to the following outline, although it is not possible here to give clear indications as to the speed and time needed to reach each one of the objectives:

(a) Preparation of young doctors for service and making a pre-selection according to personal aptitude, attitude and academic achievements to identify candidates for additional experience to prepare them as academic teachers through fellowships. At the same time the undergraduate fellowships programme needs to be continued.

(b) Assistance to central servicing health and medical institutions in the country itself (e.g. public health laboratories, a central hospital with its servicing departments) in order to bring them up to a reasonable standard, and preparing nationals as "counterparts" for the important posts to be taken over by them as soon as they are fully experienced. (See also under (a)).

(c) Preparation of other paramedical and health personnel necessary to run medical and health establishments on satisfactory technical principles and providing diagnostic and therapeutic knowledge and tools in order to assist the medical man in the application of scientific knowledge and well developed skills.

(d) Local training as soon as possible for: interns; paramedical personnel (nursing, laboratory assistants, etc.), auxiliary personnel, with a young national doctor taking over the responsibility for their training.

(e) Promotion of experience of young national doctors first at the lower level with provincial and municipal health services in order to make them ready to step into more responsible positions, preferably preceded also by a postgraduate course.

24. An experiment in undergraduate teaching with a view to arousing interest in basic medical sciences was started in 1961 in Israel. Undergraduate

education is provided for students from developing countries mainly for educating and training future teachers and research workers in basic medical sciences to be the backbone of their country's corps of medical educators. It goes without saying that teachers in clinical subjects are easier to form than teachers of basic medical sciences.

25. Assistance to postgraduate educational institutions, particularly in the field of public health, is being concentrated in a few places and countries of this Region. Doctors who have to get their postgraduate experience outside this Region are still in the majority. One of the national institutions which has developed well is the High Institute of Public Health in Alexandria, which is already receiving WHO fellows from other countries and arranged with WHO assistance, an inter-regional course in occupational health in 1961 which was fully successful. WHO assistance is continuing in providing visiting professors, e.g. in 1962 a professor in Health Education reviewed with the staff the health education teaching programme as well as the wider role of the Institute in the health education field. Institutions in two other countries are providing postgraduate training in public health and allied fields. A DPH course has been given in Lahore by the Institute of Hygiene since 1955. Further consolidation and development are under discussion with a view to making available another postgraduate training institution for fellows from various countries in addition to the School of Public Health of the American University of Beirut.

26. Postgraduate preparation of other categories of medical and paramedical personnel is expanding. Some medical faculties in Cairo, Alexandria, Lahore, Karachi, Multan, Beirut and Teheran have programmes arranged for specialists with postgraduate qualifications. Questions related to specialists' training, postgraduate qualifications, preparations of academic teachers, etc., will also be taken up in the Medical Education Conference in Teheran in October 1962.

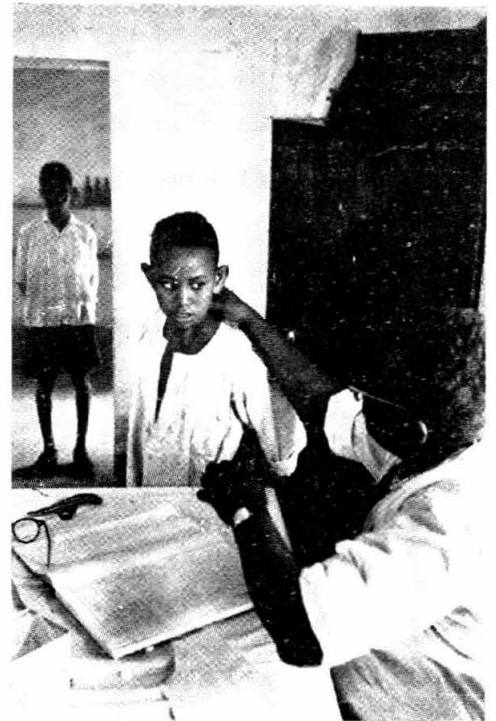


A medical assistant in charge of El Huda rural health centre chats with the family of a TB patient, during a home visiting round. He caters to more than 5,000 persons in El-Huda and the fifteen nearby villages in the Menagil extension of the Gezira.



Taking the pulse of a suspected case of smallpox on a home visit

Medical check-up of a youngster at the out-patient clinic of El-Huda. Average daily attendance: 150 patients including 70 children.



The medical assistant is also an energetic health educator during his weekly tour of El Huda and surrounding villages.

## RURAL HEALTH DEMONSTRATION AREA (SUDAN)

## HEALTH CENTRE, SANA'A (YEMEN)



Many children who report to the Sana'a health centre receive clothes produced by the local welfare society. Young mothers seeking medical assistance are also shown the proper preparation and use of locally available foods for a well-balanced diet, especially during the weaning period. Some thousand mothers and children call at the centre monthly.



A newly trained assistant nurse sees a mother at Sana'a centre: 12 Yemeni girls have already graduated and 38 more are preparing to do so.

## MCH TRAINING CENTRE, BENGHAZI (LIBYA)



Practical training of first-year students under the supervision of a WHO nurse-educator. The MCH centre graduated 11 auxiliaries in 1959 and 15 in 1961.



A second-year trainee assists in the medical check-up of a child.

27. Medical science teachers are being prepared in Karachi in the Basic Medical Science Institute which has been organized under the United States bilateral assistance to Pakistan. Post basic nursing education programmes so far exist only in Pakistan, but it is expected that in five years' time, at least two more countries will be ready to start projects of this kind.

#### AUXILIARY TRAINING

28. It may be equally helpful to review the policy of this Office with regard to auxiliary training also in the light of the various categories of countries which have been specified above. Auxiliary training is invariably carried out in most of the Region, however, assistance to projects is limited to a few countries. In 1957, assistance in this field was given to two countries, now to six. The problem of auxiliary personnel was discussed extensively during an Inter-Regional Conference in Khartoum in December 1961 in which all six WHO Regions participated. This conference may be considered as a milestone in the history of the Eastern Mediterranean Region, since it dealt with a problem that is of great importance not only throughout the Region, but is of global importance for the development of health services everywhere. It also brought into focus that this Region has at its disposal unique resources and experiences in this field, a fact which the host country, Sudan, was able to substantiate and demonstrate in a most impressive way.

29. In general terms, it is hoped that assistance in this field to individual training projects as a rule will decrease. This does not mean that this important field will receive less emphasis in regional activities - the contrary is true. However, the place of action and emphasis of work will be shifted from national training (where normally the "frontline worker" is being trained) to inter-country projects in order to provide advanced training to the teachers who train auxiliaries and, equally important, to the supervisors in the field. One project will soon start which should help to fill an important gap, that is the training of laboratory

technician tutors. Another project is under discussion, which in five years from now will certainly be in full operation, and that is the training of sanitarian tutors and supervisors.

30. There will obviously be types of auxiliaries whose training may still need help from this Office, e.g. dental auxiliaries. One project, the first of its kind, has started in Sudan. The lack of dental care is great in almost all countries of the Region. As with the medical profession the few dentists available are concentrated in the cities. This type of auxiliary is an example for future programmes which can be started and implemented if and when the basic personnel of the health team is being trained and put at the disposal of the health administrations. The "basic team" in this context is understood to be composed of the following: the medical or health assistant, the sanitarian and the public health nurse-midwife. Most countries have these three categories now in training, others have only two.

31. It does not need much explanation that WHO's assistance in the field of auxiliary training is almost exclusively limited to the second and third categories of countries (see page 20). Countries in the third category still need extensive help and WHO personnel with operational responsibilities. This assistance is at present quite substantial. WHO personnel takes care of the training itself including responsibility for administrative and organizational aspects of the project. It is planned that during the years to come the following two steps will be taken in order gradually to hand responsibility over to the Governments and have WHO functioning in its constitutional role as advisory body.

32. The first step will be to attach young doctors returning from abroad to the services of their countries and to the training projects for health personnel, preferably after some experience in operational health services.

33. The second step will be to assist in up-grading qualified and experienced auxiliaries themselves through some training, either in

inter-country courses or through training programmes specifically planned for individuals or small groups in national institutions within this Region.

34. It is expected that thus although the assistance in the field of auxiliary training will be intensified in the direction of teacher preparation, the projects in countries needing immediate assistance will decrease. The number of the country training projects of traditional health auxiliaries which amounted five years ago to two and now to six, will be in all probability in five years from now not more than two with shift in emphasis and form of assistance as outlined above. This would also, and in fact should, enable the countries to take fully into their own hands not only training of their frontline health workers, but in addition enable them to arrange in-service training and refresher courses as an integral part of their national training programmes.

#### FELLOWSHIPS PROGRAMME\*

35. The importance of the fellowships programme is fully realized by every Member State within the Region, and serious attempts have been made to improve planning for the future.

36. Most countries of the Region have achieved real, though in some cases modest, progress in the planning and implementation of their WHO fellowship programmes. Technical guidance has continued to be provided, on request, by the Regional Office to assist countries in planning their fellowship programmes at least a year ahead, with a view to securing long-term efficiency. Despite this, it must be admitted, that countries have not always followed the criteria in setting priorities. Efforts will, therefore, have to be adjusted and intensified to achieve this goal.

37. The appointment at the Regional Office during the year of a Medical Officer for Education and Training who has been devoting the greater part of his time to the fellowship programme bears testimony to the immense

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\* See also Figures I-IV

interest in this endeavour. More frequent visits to the field have been made to establish personal contacts with WHO fellows in training. The purpose of such visits is manifold. On being interviewed, the fellows' problems are explored closely and attempts at their solution are made "on the spot". The various training programmes are discussed with both the fellows and training authorities in an endeavour to help fellows obtain maximum benefit from the courses of instruction, taking into account the type and nature of their work in the future. In addition, a more adequate assessment and follow-up of the fellows' academic performance is made, and wherever possible, former fellows are interviewed and matters pertaining to their work and their ambitions are discussed.

38. The role of WHO Representatives is gaining increasing importance in helping to interpret to Governments broad aspects of the WHO fellowship programmes, particularly with regard to the selection of suitable candidates. However, it should be emphasized that procedures and methods of selection could still be improved.

39. Facilities within the Region are being explored and used more and more for placement of WHO fellows, including undergraduate medical students and paramedical personnel. The Sudan offers an example of a country of the Region whose services are being increasingly sought for placement of WHO fellows, particularly at the "auxiliary" level, when a given type of training is not as yet available in the country of origin or when the auxiliary needs some "advanced" training in a specific field.

40. The total number of fellowships awarded from 1949 up to the end of 1961 reached 1,935. The number awarded last year was 306 compared with 221 in 1960. It is interesting to note that during the year 1961, there was a sharp increase in the number of fellowships awarded to undertake courses and study visits. Another interesting finding is the continued increase in the number of intra-regional fellowships during the year which exceed those awarded by the Eastern Mediterranean Regional Office for study

in any other Region. This trend has been particularly noticeable since 1959, when the number of intra-regional fellowships was 103, in contrast with 107 and 140 in 1960 and 1961, respectively.

41. A noteworthy development has been the increase in the number of women from various countries of the Region undertaking studies in medicine and pharmacy, under WHO sponsorship. During the year under review, six WHO fellows (women) from three countries were taking up undergraduate medicine and pharmacy in medical schools in this Region. If nothing else, this reflects the growing interest of several countries in making available more opportunities for women to obtain training in these subjects. The trend will continue to have the full support of the Regional Office, taking into consideration the urgent need of some countries for professional female medical and health personnel to conduct specific programmes in their communities, including maternal and child health, gynaecology and obstetrics, etc. It is expected that with increasing numbers of girls completing their secondary education in the Region, more of them will be considered for WHO fellowships in the future.

42. In the next five years or so, the general trend of the fellowship programme is expected to be directed towards:

(a) Promoting adequate planning by respective countries in the light of health needs and priorities vis-à-vis the overall national health programmes.

(b) Fostering and strengthening public health training at a post-graduate level within institutions of the Region. Use is already being made of the High Institute of Public Health, a WHO-assisted project in Alexandria, and the School of Public Health, American University of Beirut, for training WHO fellows at post-graduate level.

(c) Sponsoring fellowships for basic professional nurses to study at the Higher Institute of Nursing, Alexandria, the American University, Beirut,

and the Nursing College, Khartoum, all of which receive assistance from WHO, and any other suitable institution for fellows from Regional countries who do not yet have training facilities for professional education in nursing.

(d) The provision of internship studies for medical undergraduates with a view to making more adequate facilities for them to spend the period of internship in their countries of origin or in neighbouring countries with similar circumstances.

43. To sum up, efforts will be made to focus the fellowships programme on "centres of gravity" in the overall national health programmes which manifest priority need for more trained health personnel.

44. Looking further ahead, it is possible, indeed probable that there will be a greater increase in the number of WHO fellowship awards next year, which will form a genuine investment for future programmes. This progress is expected to come about from slow, solid work, together with continued mutual cooperation and understanding between the Member States and the Regional Office. In this connexion tribute should be paid to the countries for their valued assistance throughout the year which has contributed substantially to the promotion of the overall programme. The ground is richly fertile for even further progress.

Figure I

**NUMBER OF FELLOWSHIPS AWARDED BY WHO EMRO  
1949 - 1961 - FELLOWSHIP EXTENSIONS NOT INCLUDED**

COUNTRY	YEAR													TOTAL
	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	
ADEN	-	-	-	-	1	-	-	-	-	-	-	-	-	1
CYPRUS	-	1	-	3	2	-	-	-	-	1	4	3	11	25
ETHIOPIA	4	13	10	9	6	1	5	3	7	6	5	7	8	86
IRAN	8	10	7	27	34	16	29	15	34	38	27	13	21	279
IRAQ	1	2	3	13	19	6	9	7	12	18	16	12	22	140
ISRAEL	1	2	9	15	12	7	7	5	10	11	11	10	8	108
JORDAN	-	1	5	2	4	3	6	3	5	8	13	18	18	86
KUWAIT	-	-	-	-	-	-	-	-	-	-	-	-	3	3
LEBANON	1	4	8	6	17	8	8	9	18	17	15	13	12	136
LIBYA	-	-	1	5	6	4	7	3	9	5	13	12	7	72
PAKISTAN	7	4	12	12	14	4	13	4	11	10	20	19	39	169
SAUDI ARABIA	-	2	4	3	3	1	4	4	5	1	14	14	15	70
SOMALIA	-	-	-	-	-	-	5	1	6	9	12	12	20	65
SUDAN	-	1	5	1	8	5	7	7	20	19	25	28	28	154
SYRIAN A.R.	-	4	10	5	16	6	22	10	17	6	8	8	16	128
TUNISIA	-	-	-	-	-	-	-	12	14	12	19	22	16	95
UAR	10	7	10	9	31	18	33	11	26	38	12	17	31	253
YEMEN	-	-	-	-	-	2	12	2	2	-	3	13	31	65
<b>TOTAL</b>	<b>32</b>	<b>51</b>	<b>84</b>	<b>110</b>	<b>173</b>	<b>81</b>	<b>167</b>	<b>96</b>	<b>196</b>	<b>201</b>	<b>217</b>	<b>221</b>	<b>306</b>	<b>1935</b>

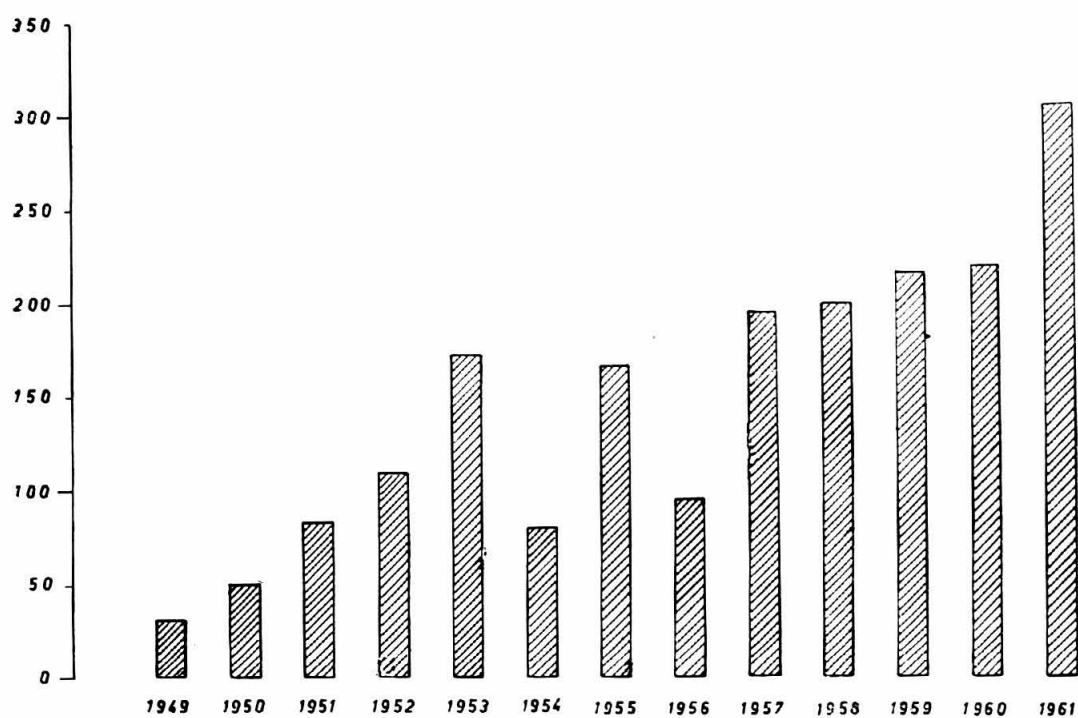
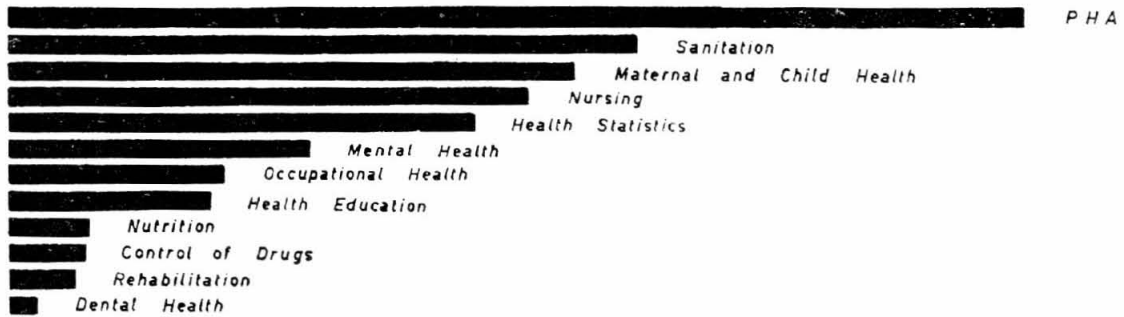


Figure II

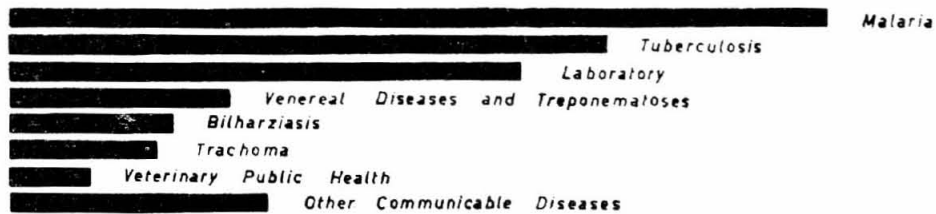
# NUMBER OF FELLOWSHIPS AWARDED FROM 1949 THROUGH 1961 BY SUBJECTS

0 10 20 30 40 50 100 150 200 250

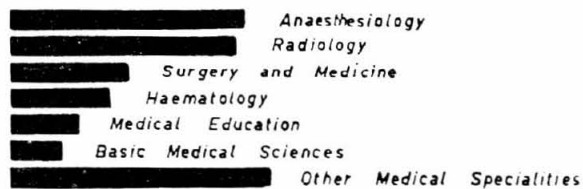
## i HEALTH ORGANIZATION AND SERVICES



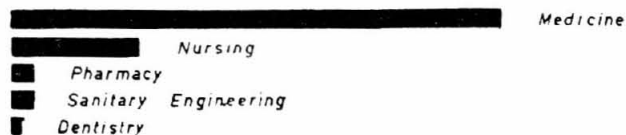
## ii COMMUNICABLE DISEASE SERVICES



## iii MEDICAL EDUCATION, CLINICAL AND BASIC MEDICAL SCIENCES



## iv UNDERGRADUATE STUDIES (without extensions)



## EXTENSIONS OF UNDERGRADUATE STUDIES



FELLOWSHIPS BY TYPE OF STUDY 1949 - 1961.

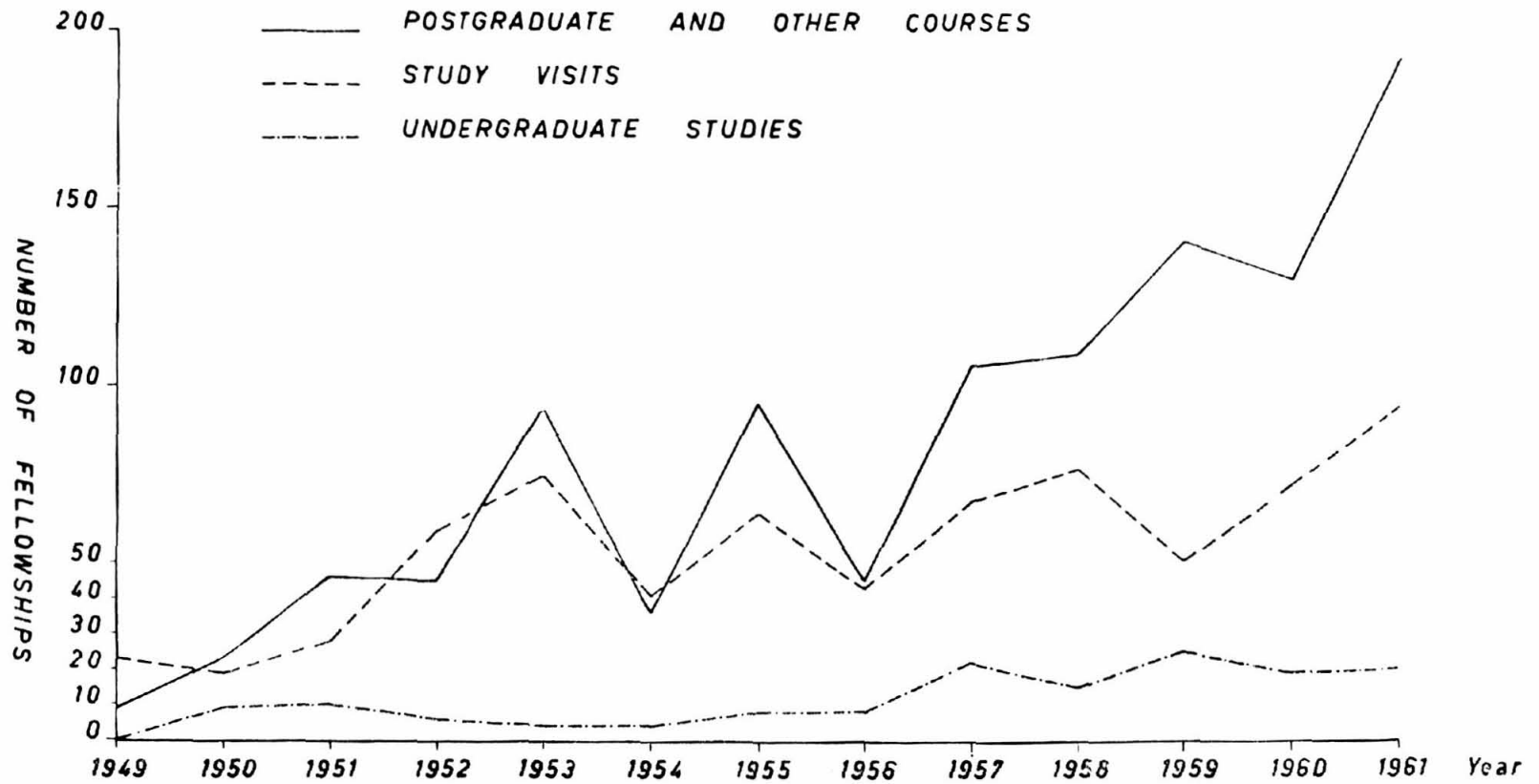
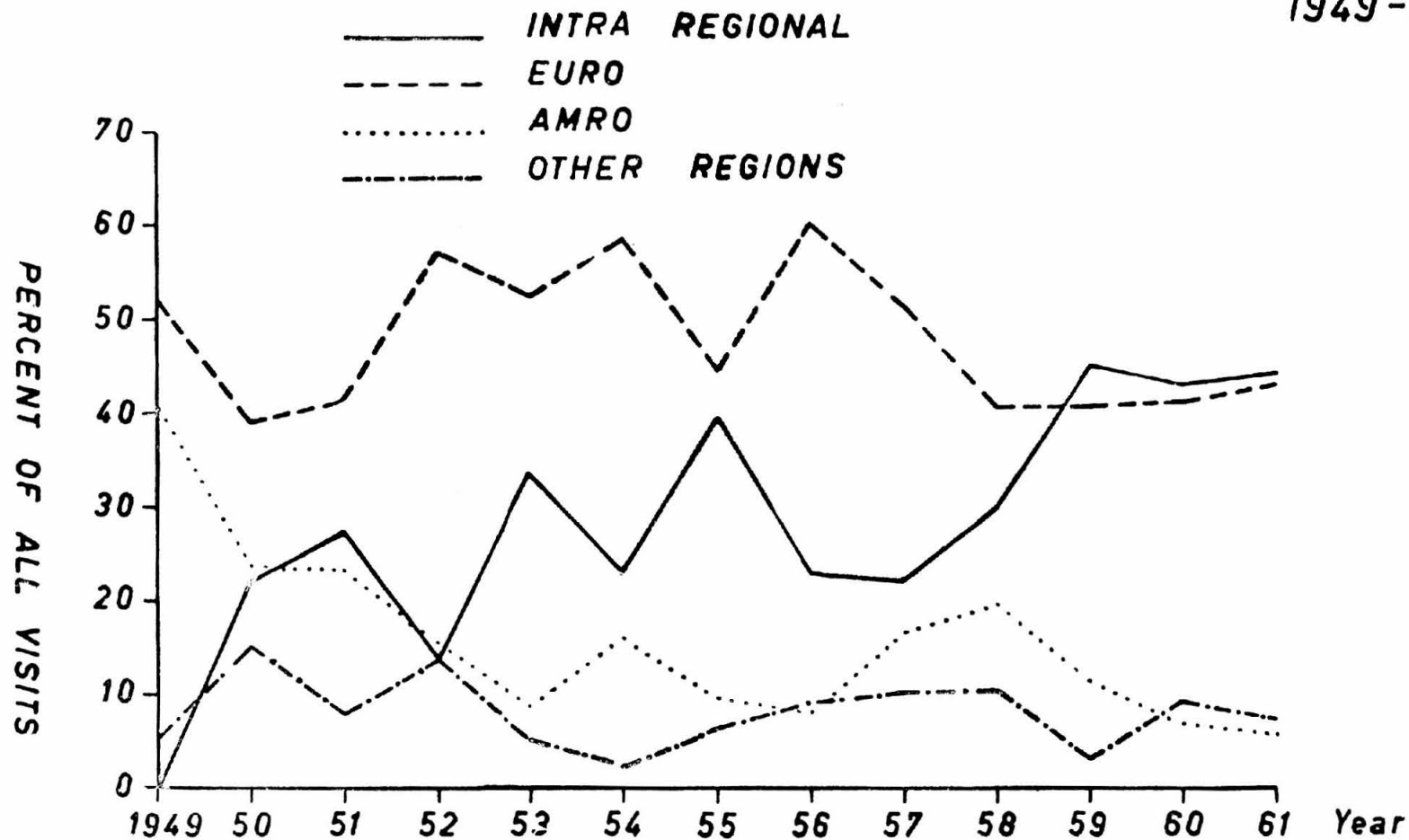


Figure III

**STUDY VISITS BY WHO EMRO FELLOWS  
PERCENTAGE DISTRIBUTION AS PER REGION OF STUDY**

**1949-1961**



COMMUNICABLE DISEASES

MALARIA ERADICATION\*

INTRODUCTION

45. The Eastern Mediterranean Region, comprising twenty-five countries and territories with a total population of about 210 million, had originally about 172 million people living in malarious areas. Extensive malaria control operations through residual spraying of chlorinated hydro-carbon insecticides have led to a dramatic reduction in the incidence of malaria and even to the eradication of this disease from certain countries. Since 1955 and after the Eighth World Health Assembly passed its historic resolution in that year, urging Governments to convert their malaria control programmes to those aimed at eradication, almost every country in this Region has started eradication or pre-eradication programmes. Such activities have resulted in protection of about 36 million inhabitants constituting 21% of those who originally lived under malaria risk. However, malaria is still a major hazard which has devastating effects both on health and economic developments as seen lately in Somalia following the unusual floods that hit the country late in 1961. The epidemic of malaria that followed these floods affected about half a million of the population representing one-third of the total inhabitants.

46. The eradication of malaria is conceived as a global public health undertaking in which all Governments are morally obliged to participate. Apart from the apparent socio-economic benefits gained through the eradication of this disease, two main factors are now pressing Governments to expedite their eradication programmes. The first is related to the problem of the development of resistance by the malaria vectors to the insecticides in common use, such as DDT, BHC and DLD. Such resistance, if widespread, would necessitate the use of more expensive insecticides such as the

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\* See: Document EM/RC12/4

organo-phosphorous compounds which also have a shorter residual effect and will necessitate repeated application to interrupt malaria transmission thus involving more local expenditures as well as stricter safety measures. The other pressing factor is connected with the development of major irrigation schemes such as the High Aswan Dam in the United Arab Republic, the Indus river project in Pakistan, as well as others in Sudan, Iran and Iraq, which will certainly increase the potentialities of malaria and make any undertaking of future malaria eradication extremely expensive and difficult.

47. As the malaria problem in Pakistan represents 55% of the total Regional malaria burden, the successful launching of the Pakistan malaria eradication programme in 1961 has raised hopes for the ultimate eradication of this disease from the whole Eastern Mediterranean Region, in the near foreseeable future. It is gratifying to note also, that within the next four years, Lebanon, Israel, Libya, Jordan, Syrian Arab Republic, Iraq and the northern two-thirds of Iran will successively declare the eradication of the disease.

48. Governments with malaria eradication programmes underway or preparing the grounds for such programmes in the near future, are realizing the collateral benefits arising from such an undertaking. The training given to, and the experience gained by all public health workers engaged in such programmes both in the organizational and administrative fields as well as in effective planning based on technical knowledge and constant evaluation, constitute an asset to Governments in promoting public health activities. Moreover, the concept of malaria eradication, based on total coverage and the need for efficient vigilance services during the maintenance phase to prevent the re-introduction of the disease, has brought to the attention of the Governments the need and urgency to strengthen and extend the basic rural health services in all areas, apart from effecting the necessary vigilance service, which will cater to the health needs of all the population. The active steps taken by the Governments in this connexion constitute their greatest contribution to implementing malaria eradication or pre-eradication programmes.

STATUS OF MALARIA ERADICATION ACTIVITIES IN THE EASTERN MEDITERRANEAN REGION

49. As seen in the Table (page 43), there are five countries or territories with a total population of 1.5 million that have been freed or were originally free from malaria, namely, Aden Colony, Cyprus, French Somaliland, Gaza Strip, and Kuwait. A vigilance system has been established in these areas, and attempts to eradicate the vector species are being pursued with success to obviate any risk of re-introduction of the disease.

50. Eradication programmes are under way in eight countries (involving 139 million population): Iran, Iraq, Israel, Jordan, Lebanon, Libya, Pakistan and the Syrian Arab Republic. Both Tunisia and the United Arab Republic may be considered in the preparatory phase, and both are expected to start their eradication programmes, according to the newly modified plans of operation, early in 1963. Thus the whole northern geographical border of this Region extending from Pakistan to Tunisia, may be considered under eradication, and there is every chance of success as already demonstrated by the epidemiological assessments of the nearly completed country-wide programmes in Lebanon, Iraq, the northern two-thirds of Iran, Israel, Jordan and the Syrian Arab Republic.

51. Pre-eradication programmes covering 27 million of the population have already been initiated in Ethiopia, Saudi Arabia, Somalia and Sudan. Although all these countries have demonstrated, through previous pilot operations, the technical feasibility of malaria eradication, and have already extended eradication activities to part of their territories, yet the lack of professional personnel, the paucity of the basic rural health services, and the nomadic problem have to be tackled to ensure sound planning for implementing future malaria eradication programmes which will guarantee a successful issue.

52. Pre-eradication programmes imply the synchronized development and extension of the basic rural health services with the malaria eradication service in each country. Both these services should participate in

conducting malaria surveys and anti-malaria activities, thus leading to fuller knowledge of the epidemiology of malaria, and at the same time promoting health activities and other developments necessary to the launching of eradication programmes.

53. As regards the countries and territories which have not so far been committed to eradication, such as Aden Protectorate, Bahrein, Muscat and Oman, Qatar, Trucial Oman, and Yemen, involving a population of about 5 million living under malaria risk, it is gratifying to note that Aden Protectorate, with the largest population except for Yemen, has already requested the services of an expert to visit the territory in October 1962 to assess the situation. This will be of help in developing a plan for a pre-eradication programme. Upon the request of the Yemenite Government a team of national and international malaria workers, by arrangement between Saudi Arabia and the Regional Office, surveyed the border areas in Yemen in October 1961. The results showed a holo-endemic malaria situation especially in the coastal strip of Yemen and stimulated the Government to request assistance from WHO to implement a pre-eradication programme early in 1963.

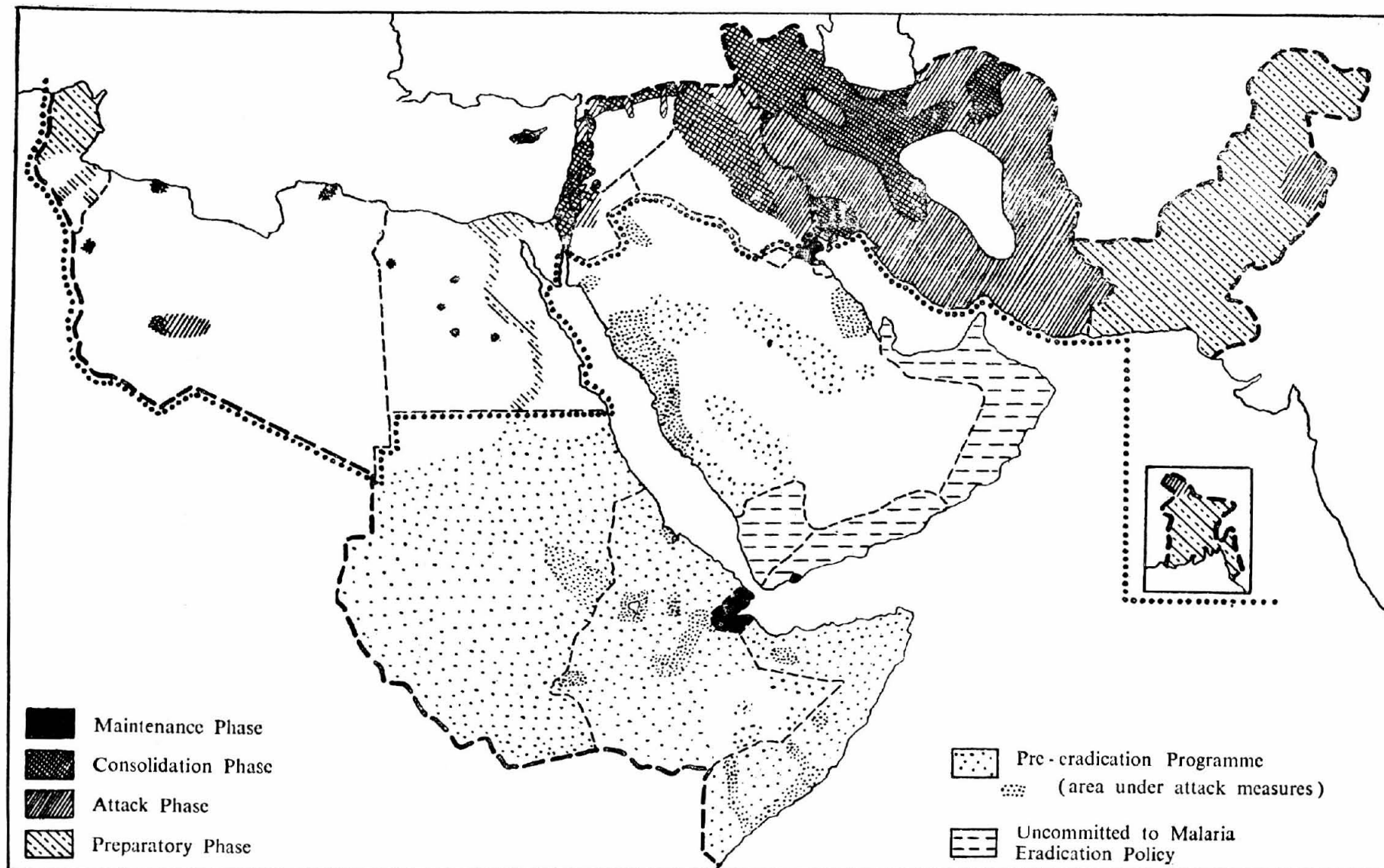
54. The above account shows the progress achieved in the field of malaria eradication, and the excellent response of all countries and territories in this Region.

#### PROGRAMME AND PLANNING ACTIVITIES

55. Plans of Operation. During this period, a new plan of operation for malaria eradication in Iran has been developed. This new plan has been based on the epidemiological assessment of the previous eradication activities in each ostan (province), and indicates the steps to be taken until the end of the consolidation phase as well as guaranteeing a vigilance service by the existing and newly established rural health structure during the maintenance phase.

56. The plan of operation for the United Arab Republic has been modified owing to recent changes in the organization of the public health services,

TYPES AND PHASES OF MALARIA ERADICATION ACTIVITIES IN COUNTRIES OF THE REGION - June 1962

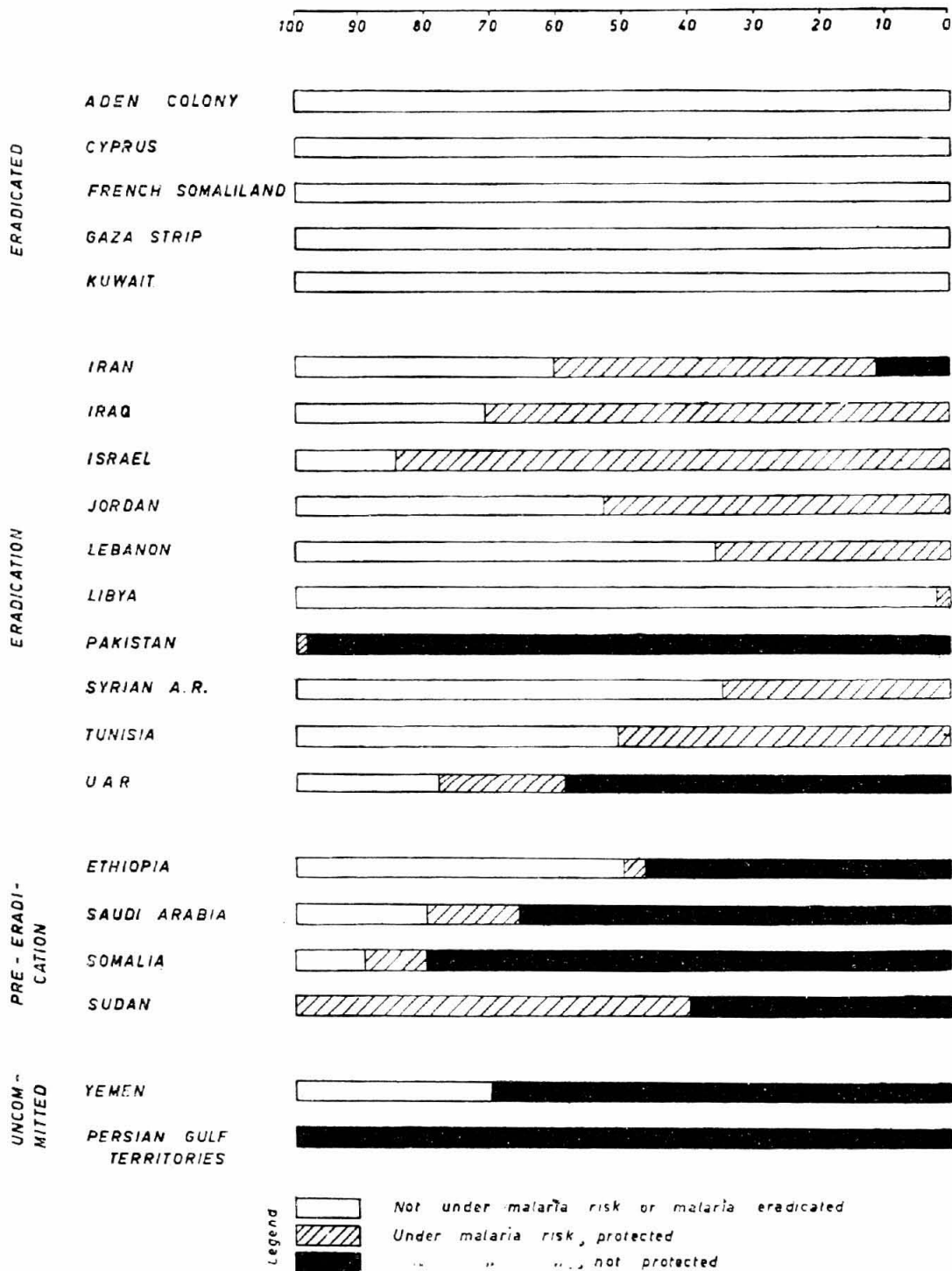


x  
 ..... North of this boundary : malaria eradication programmes  
 ..... South of this boundary : pre-eradication programmes

Figure V

## STATUS OF MALARIA PROGRAMMES 1961

RELATIVE DISTRIBUTION OF TOTAL POPULATION IN EACH COUNTRY  
ACCORDING TO EXPOSURE TO MALARIA



especially as related to the decentralization of these services at provincial level and the establishment of rural health centres, each to serve a population of 5,000. These centres, according to the new plan of operation, will be responsible, under the guidance and supervision of the National Malaria Eradication Service, and the malaria stations in the provinces, for executing the spraying operations as well as surveillance activities.

57. In accordance with WHO and UNICEF policy, each malaria eradication programme is evaluated at the end of the year by WHO senior advisers, attached to country programmes, national counterparts and Regional Office staff, and an annual plan of action is drawn up based on the results of this evaluation. These plans of action are used by UNICEF as an annex to their annual recommendations to the UNICEF Executive Board for continued assistance to the malaria eradication programmes.

58. In accordance with WHO policy regarding the establishment of pre-eradication programmes in developing countries, plans of operation have already been developed for Somalia, Ethiopia and Saudi Arabia. The plan for Sudan is expected to be completed by the end of 1962. As mentioned before, the emphasis in such pre-eradication programmes is laid on the establishment and development of the malaria service together with the development of basic rural health services and the utilization of both these services in completing the information regarding the epidemiology and distribution of malaria in the whole country. In these pre-eradication programmes, aiming at the preparation of the countries to implement future eradication programmes by stages, stress is being placed on training both professional and auxiliary personnel in the malaria field as well as in rural health activities, as the future implementation of the eradication programme will depend on the existence and homogeneous distribution of adequate trained personnel.

59. No further pilot projects are being recommended in this Region, as the feasibility of malaria eradication through residual spraying alone or

supplemented by other means, has already been demonstrated. The planning of pre-eradication programmes is conceived on a country-wide basis with pilot malaria eradication operations in one or more areas, in order to tackle the local technical problems peculiar to the country or to test the administrative machinery of the malaria eradication service in applying eradication measures. These pilot operations also provide in-service training for graduates from the malaria training centre, and set a pattern for future eradication activities to be carried out by stages.

60. WHO Staffing. Advisory services in various specialities are provided to Governments. Such staff already working in the various malaria programmes in the Region comprise: 13 malariologists, 7 entomologists, 4 sanitary engineers, 9 sanitarians, 4 administrative officers and 5 technician/instructors. For those countries planning for future malaria eradication programmes, there is an urgent need to establish and build up their technical and administrative manpower as well as their rural health infrastructures prior to implementing such programmes. In this connexion, the Governments' attention is drawn to the WHO Director-General's memorandum of 15 March 1962 confirming that the Regional Directors are at all times ready to make available such advisory services to Governments according to their needs.

61. The expansion of the malaria eradication programmes has created a great demand for senior professional staff, and WHO has already established procedures for interviewing and circulating names of suitable candidates to all Regions, prior to selecting, training and assigning such personnel to any particular posts. Moreover, the system by which a reserve pool of experts in different malaria specialities is available in each Region, has overcome the delays in recruitment which were previously experienced.

62. National Staffing. The national training centre in Ethiopia and the two in Pakistan are helping to meet the need for professional as well as auxiliary staff. In addition, the Regional Office has stimulated and

assisted in establishing such centres in Saudi Arabia and the Sudan. The Regional Malaria Eradication Training Centre which opened in 1958 in Cairo has fulfilled its objectives and has provided training for 114 senior professional personnel and 168 junior personnel. As the WHO-assisted centres are developing to train national personnel in each country, the Cairo training centre has ceased to have Regional status. WHO policy in raising the technical standard of the national staff is to award fellowships for instructors in these national centres and for senior personnel to attend WHO-sponsored refresher courses given in certain specialities and also for the latter to exchange visits with other scientific workers.

63. The Fourteenth World Health Assembly\* appealed to all Governments to attach counterparts to WHO staff as early as possible and to utilize WHO malaria fellowships for the additional training of these counterparts abroad, in order that they might take on the full responsibility for the eradication or pre-eradication programmes.

64. During the period under review, 68 fellowships were given to candidates from countries of this Region to attend international training centres, apart from 16 who were granted travel or scientific-worker-exchange fellowships. Experience has shown that senior public health administrators make the best executives for running extensive programmes such as those of malaria eradication, especially after being given fellowships to attend a short course on malaria eradication at an international training centre.

65. With the decrease of malaria, stress has been placed on strengthening the courses on the epidemiology of the disease and the methodology of entomological evaluation of spraying campaigns. Refresher courses organized by national training centres, as well as annual meetings of professional personnel in each country, convened usually at the end of each year to prepare annual plans of action, provide the best media for improving both the technical knowledge and "esprit de corps" of national staff.

\* See: Resolution WHA14.38

66. During 1961, the number of national professional personnel engaged in the malaria eradication schemes of this Region, totalled 384 (including malariologists, entomologists and sanitary engineers), as well as 4,176 auxiliary personnel (including sector chiefs, supervisors and technicians).

67. The sum allocated for malaria eradication in this Region for 1962 is approximately one million US dollars, which represents over one fifth of the total allocations to the Region for all activities. Most of the expenditures cover advisory services, fellowships, and some supplies and transport. In the case of Pakistan, due to the delay in reaching an agreement with other subsidizing agencies, WHO provided US \$491,000 for supplies to expedite the launching of the programme in 1961 and part of 1962. Under the Emergency Fund, WHO also helped in providing the necessary anti-malaria drugs to the flood-stricken population of Somalia.

68. UNICEF is maintaining its assistance to the global malaria eradication programme at an annual ceiling of US \$10 million, of which this Region is receiving in 1962 about US \$1,095,000 for the programmes of Iran, Iraq, Jordan, Lebanon and the Syrian Arab Republic. US AID is maintaining its assistance to malaria eradication programmes during 1962 specially in Ethiopia, Iran, Jordan and Libya, and has promised future support to both the Pakistan and the United Arab Republic programmes.

69. The fact that every country in this Region is contributing to the World Health Organization's scheme for issuing postage stamps on malaria eradication, and their donation of a percentage of the sales proceeds or a number of stamps for the benefit of the Malaria Eradication Special Account, reflects the interest and importance given to malaria eradication in the health programme of this Region.

70. The Governments' attention is drawn to the gradual incorporation of the provisions for all malaria eradication activities into the Regular budget of the Organization, as from 1962 to be fully completed by the end of 1964. This will mean that Governments who are anxious to complete their eradication

programmes successfully, must give them priority in their WHO programming. WHO will still continue its efforts to obtain voluntary contributions to provide additional financing of malaria eradication programmes.

#### COORDINATION ACTIVITIES

71. Because of the international character of the malaria eradication programme, and the importance of efficient quarantine measures to prevent the introduction of disease across borders, especially through mass nomadism and transhumance between neighbouring countries, the Regional Office has been very active in stimulating neighbouring Governments to negotiate bilateral agreements to enable malaria workers to meet periodically and coordinate their activities especially in border areas. To date, such agreements have been promulgated between Iran and Iraq, Sudan and Ethiopia, Saudi Arabia and Yemen. The participation of Pakistan in the border meetings with India and Burma is an example of inter-regional coordination. The recent Conference held in Teheran early in May 1962 in which Afghanistan and India from the South East Asia Region, Turkey and USSR from the European Region, and Pakistan, Iraq, Iran and the Syrian Arab Republic from this Region participated, proved to be most successful in coordinating planning and executing malaria eradication measures along the borders, as well as in exchanging information on the progress so far achieved in the eradication programmes, and on methods of tackling certain technical problems connected with the ecology or resistance of the malaria vectors as well as those related to nomadism and mass movement of populations.

72. The recommendations of this Conference form a valuable contribution to the epidemiology of malaria and the experience gained in eradication in countries having almost one-third of the total world population that originally lived under malaria risk. Attention is drawn to the recommendations of the Conference which are annexed to the Malaria Eradication document.\*

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\* EM/RC12/4

73. The WHO Inter-Country Evaluation Team with its headquarters in Beirut has also been active in coordinating the eradication activities in Iraq, Jordan, Lebanon and the Syrian Arab Republic. As these programmes are now well advanced, a coordinated plan of operation is being developed with the objective of stimulating the Governments concerned to expedite the completion of the consolidation phase according to a definite schedule, and to invite these countries to make arrangements for periodic exchange of epidemiological information on malaria. Moreover, this plan will define the role of the Governments in strengthening and expanding basic rural health services to enable efficient malaria vigilance service during the maintenance phase.

74. The Malaria Eradication Coordination Unit attached to the Regional Office is maintaining its coordinating role with the Division of Malaria Eradication at Headquarters, as well as with UNICEF and US AID, in the planning, execution and financing of the Regional Malaria Eradication Programme, including the training activities.

#### FUTURE PROSPECTS

75. One may take heart from the progress of eradication schemes in the Region, especially after the launching of the Pakistan programme; all countries with the exception of a few small territories along the Gulf area, are now involved.

76. Technical problems such as the development of vector resistance to chlorinated hydrocarbon insecticides, (A. stephensi, Iran, A. pharoensis, United Arab Republic) and the mass movements of nomadic populations, are proving to be of lesser importance in the implementation of malaria eradication programmes than the handicap of inadequate coverage of the basic rural health services in most countries of the Region, and even in some countries that are advanced in their eradication schemes.

77. It is heartening to note that the 1961 epidemiological assessment of the six countries that started their eradication schemes earlier, showed that among those under the consolidation phase (population 12,077,000) out of 1,213,106 slides examined, 853 were positive, i.e. .07% malaria incidence.

STATUS AND DEVELOPMENT OF MALARIA PROGRAMMES IN THE  
EASTERN MEDITERRANEAN COUNTRIES - 1961  
(POPULATION IN THOUSANDS)

Type of Programme	Countries	Total No. of Population	Population under Malaria risk	Population Protected by all Methods	E r a d i c a t i o n		
					year start attack	year ending consolidation	Type
Malaria eradicated or originally free	A DEN COL.	150	150	150	Malaria eradicated since 1950		
	CYPRUS	581	581	581	Malaria eradicated since 1949		
	FR. SOMALIA	70	70	70	Malaria eradicated since 1957		
	GAZA STRIP	350	350	350	Malaria eradicated since 1954		
	KUWAIT	219	-	-	Free from malaria		
<b>T O T A L</b>		<b>1,370</b>	<b>1,151</b>	<b>1,151</b>			
Eradication	IRAN	21,500	13,000	10,562	1957	1971	by stage
	IRAQ	6,500	4,600	4,600	1957	1964	countrywide
	ISRAEL	2,200	2,200	2,200	1957	1963	countrywide
	JORDAN	1,700	906	906	1959	1965	countrywide
	LEBANON	1,880	683	683	1957	1964	countrywide
	LIBYA	1,250	31	31	1959	1964	countrywide
	PAKISTAN	93,808	93,808	1,363	1961	1974	by stages
	SYRIAN ARAB REP.	4,561	1,588	1,588	1956	1964	countrywide
	TUNISIA	3,783	1,914	1,914 )	Attack phase expected to start in 1963		
	U.A.R.	26,080	20,259	4,931 )			
<b>T O T A L</b>		<b>163,262</b>	<b>138,989</b>	<b>28,778</b>			
Pre-Eradication	ETHIOPIA	20,000	10,000	600			
	SAUDI ARABIA	5,000	4,000	716			
	SOMALIA	2,000	1,776	182			
	SUDAN	11,390	11,390	6,800			
<b>T O T A L</b>		<b>18,390</b>	<b>27,166</b>	<b>8,298</b>			
Uncommitted countries (with limited control)	A DEN PROT.	660	660	-			
	BAHREIN	147	147	-			
	MUSCAT & OMAN	550	550	-			
	QATAR	40	35	-			
	T. OMAN	86	86	-			
	YEMEN	5,000	3,500	-			
<b>T O T A L</b>		<b>6,483</b>	<b>4,978</b>	<b>-</b>			
<b>GRAND TOTAL</b>		<b>209,505</b>	<b>172,284</b>	<b>38,227</b>			

TUBERCULOSIS\*

UNICEF/WHO JOINT COMMITTEE ON HEALTH POLICY

78. Most important to the Region was the review by WHO and UNICEF of the progress made by these agencies in national tuberculosis control programmes and their decisions concerning future trends of assistance, as discussed during the UNICEF/WHO Joint Committee on Health Policy held in Geneva on 31 January to 1 February 1962.\*\* In a background document for this meeting\*\*\* WHO proposed a wider application of the present technical knowledge in tuberculosis control, but developed locally, tested and evaluated in a pilot area, and the optimum operational conditions adopted for expansion throughout the country. WHO also advocated continued training of specialized and general health services personnel for carrying out tuberculosis control work.

79. UNICEF has agreed to give assistance along these lines recommended by WHO. Following are excerpts from the Committee Report:

"(a) The highest priority should be given to reducing the spread of tuberculosis through domiciliary and ambulatory chemotherapy of the infectious cases and to increasing the level of specific resistance in the community to unavoidable infection through BCG vaccination.

(b) UNICEF aid would be given to two stages of a developing national control programme: first to the development by the national pilot area project of control measures that can be operated effectively as permanent public health measures with available technical and economic resources, and only thereafter, when these measures have proved effective, to their gradual extension to an increasing proportion of the population provided that this extension is continuously guided and assessed by the national pilot area project, that it is operated through the existing public health services and that it permits a constant level of efficiency to be maintained, particularly with respect to the regularity of drug taking.

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\* See: Document EM/RC12/5

\*\* Report of the Thirteenth Session held at the Headquarters of WHO  
JC13/UNICEF-WHO/8, 7 February 1962

\*\*\* JC13/UNICEF-WHO/2



(ABOVE) A home visitor from the Tuberculosis Control Centre (Beirut) chats with children whose tuberculous mother has just been hospitalized. They will be further examined at the Centre, then protected by BCG vaccination and chemoprophylaxis (BELOW).



The physician and social workers of the TB Centre interview another woman who was found to be tuberculous. The Centre records will guide her treatment and the investigation of her contacts at home.



## TB CONTROL (LEBANON)

In the mobile unit of the TB Centre, a young patient has been X-rayed and found cured. Early lesions of tuberculosis may be treated at home — as in this case.



**BCG CAMPAIGN  
(PAKISTAN)**

"It's not too bad", this little boy seems to say, after having faced the vaccinator's needle bravely.



Zora Mohamed becomes the 20 millionth child in Pakistan to be tested for tuberculosis.



Pupils of Barikot Middle School carrying on with their lesson while schoolmates line up for tuberculin test.

Members of the BCG team in Swat (Western Pakistan) journey over miles of mountain track on foot to cover every single village. The nurse hides her face behind a veil so as not to offend the more orthodox villagers.



The Committee shares the opinion of WHO that there is a considerable need for flexibility in determining the form and extent of the assistance to be given to Governments since the technical and economic starting points of national tuberculosis control programmes vary widely.

The Committee also believes that UNICEF, on a short-term basis, should continue to give assistance to certain existing WHO-approved control activities pending their absorption by the expanding national control programmes as outlined above. Thus UNICEF could usefully continue to support existing mass BCG campaigns provided a satisfactory technical and operational performance is maintained and to supply drugs to tuberculous cases reliably diagnosed by existing case-finding facilities provided effective administration of such drugs for the necessary prolonged period of time can be ensured.

The Committee stressed the importance of making full use of secondary chemoprophylaxis, for the protection of young children living in close contact with infectious cases as recommended by the WHO Expert Committee on Tuberculosis."

#### FREEZE-DRIED BCG

80. Another important development that has taken place is WHO's approval, on 12 July 1961 for the use of freeze-dried BCG, after five years of co-operative studies conducted by laboratories in Czechoslovakia, Denmark, France, Japan, Poland and the United Kingdom. This is a very important step forward, as it will solve the paramount difficulty in tropical climates of maintaining liquid BCG vaccines at sufficiently low temperature to ensure their potency.

81. Certain problems of administration will come up, however. Field technicians will have to be taught the correct procedures of reconstituting the dried vaccine into the liquid form. Additional syringes, needles and containers will also have to be provided. The most important policy problem however would be the practicability of producing freeze-dried BCG in national laboratories already producing liquid BCG. WHO does not encourage production by too many national laboratories, as standardization of freeze-dried BCG is difficult, and also expensive. It is desirable that Governments wanting to introduce freeze-dried vaccine should purchase stocks from a few reputable laboratories whose products have had wide application and acceptance.

82. At the Joint Committee on Health Policy meeting mentioned above, it was recommended that UNICEF assistance should be confined to providing freeze-dried BCG in selected areas where its use would have technical and operational advantages. For the time being UNICEF would not give assistance to the establishment of new production facilities for freeze-dried BCG, but might do so in the future.

83. In so far as this Region is concerned, these policy decisions on tuberculosis control have stimulated Governments to review their own tuberculosis control programmes and to consider how the Joint Committee on Health Policy decisions would affect such programmes. Several of the countries have already undertaken prevalence surveys initiated with assistance from WHO and UNICEF. Jordan, Libya, Pakistan and Syria have terminated their surveys. The Iraq survey which began with WHO assistance, is continuing under the direction of the national survey team. Sudan has made a survey of the Blue Nile Province. Ethiopia and Somalia are expecting their mobile X-ray equipment and to train their field personnel. The United Arab Republic has completed the prevalence survey of the Qalyub Demonstration Area. The above countries, with the exception of Libya, as well as Iran, Israel and Lebanon, have already established tuberculosis demonstration and training centres with WHO/UNICEF assistance. These projects are now operating under purely national auspices, with the exception of Ethiopia and Somalia, which continue to receive WHO/UNICEF aid.

84. All countries in the Region with the exception of Kuwait, Saudi Arabia and Yemen have in the past received WHO and/or UNICEF aid for their BCG vaccination programmes. They are now being run exclusively by their own Governments, although Iran and Pakistan continue to receive UNICEF aid. The elements for tuberculosis control in these countries, therefore, already exist, but how to utilize them more effectively has been preoccupying national public health administrators as well as WHO and UNICEF.

85. The concept of a national tuberculosis pilot area as proposed by WHO has gained ground in many of the countries. Kuwait established its project in January 1962 with WHO assistance. Libya, Pakistan and Saudi Arabia expect to start their pilot area projects in the latter part of 1962. Cyprus, Jordan, and Syria have already requested WHO/UNICEF aid for similar projects. Tunisia has continued to develop the Tuberculosis Training Centre. Courses for X-ray technicians are going on, and statistical methods are being demonstrated for school campaigns and the follow-up of cases under domiciliary chemotherapy and chemoprophylaxis. The national pilot area project in Sousse, WHO assistance to which was completed in 1961, has extended its field of operations to the neighbouring governorates in a pattern which the Government expects to adopt for the rest of the country. These projects have also served to orient a group of doctors from all regions undertaking tuberculosis courses at the Carlo Forlanini Institute of Rome, in public health methods in tuberculosis.

86. Training of professional and auxiliary personnel in tuberculosis control is assuming greater importance with the concept of integrating simple tuberculosis control procedures into the routine of general public health workers. While Tunisia expects to fill the need in the Region for French-speaking workers, it is deemed desirable to start a similar regional course in the English language. The possibility of establishing this in Baghdad is being explored.

87. The usual approaches for tuberculosis control already practised in some countries, do not fit certain other countries of the Region due to geographical, economic and cultural circumstances. Among these may be included the Aden Protectorate and Yemen. Tuberculosis control has had to be integrated in their general health service work, utilizing mainly tuberculin testing for case-finding, and BCG vaccination and limited chemoprophylaxis for prevention. Where X-ray diagnosis is possible, domiciliary chemotherapy, with INH and PAS is undertaken. Training of general health service personnel in the above techniques is also routine.

88. All Ministries of Health in the Region have been informed of WHO's policy on the use of freeze-dried BCG, and information on procurement costs has been supplied, to enable Governments to purchase suitable freeze-dried vaccines for their BCG programmes.

#### ENDEMO-EPIDEMIC DISEASES

##### BILHARZIASIS

89. Various bilharziasis projects are in operation in Iran, Iraq, United Arab Republic and Yemen. In the last mentioned country a WHO short-term consultant initiated a survey and the control of the disease, and undertook the training of sanitarians in Sana'a. They underwent further training in Cairo during their fellowship visits to the United Arab Republic and the Sudan. The control work in Yemen is proceeding in Taiz under the supervision of the WHO public health adviser. The comprehensive project established at Kafr El Dawar in the United Arab Republic, by the Government, with the assistance of WHO and UNICEF is making progress. The area, which has a population of 250 thousand, was chosen because no control measures had been undertaken there and the base-line data on the incidence, prevalence and transmission cycle of bilharziasis could therefore be obtained. It offers a variety of aspects of the problem as it comprises purely rural areas, industrial areas and areas which are under community development reform and reclamation. It is also intended that this project should be a field for research in the application of new molluscicides.

90. The specific objectives according to the plan of operations, are:

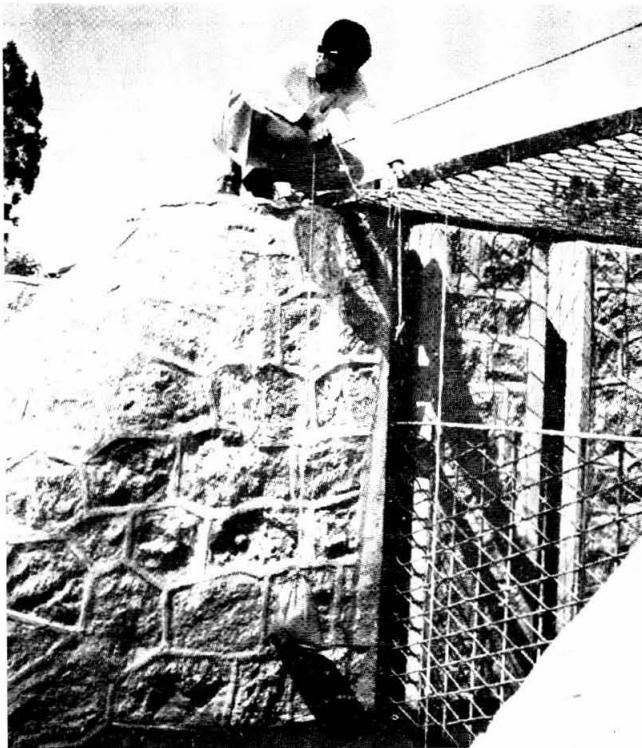
"1. To design and test control measures to determine the most effective and economical means of controlling bilharziasis under Egyptian conditions. 2. To develop appropriate evaluation procedures including cost analysis methods. 3. To develop organizational procedures for an integrated inter-departmental programme for the control of the disease. 4. To train professional and auxiliary personnel in the various phases of the work envisaged."



AN EGYPTIAN HOLLAND : The Mahmoudia Canal, a 50-mile long perennial irrigation and navigation water-way connecting the western branch of the Nile with the Mediterranean, crosses the Alexandria suburb of Kafr el Dawar. This rural area, still echoing the sounds of the rivetting gangs and weavers in nearby factories, is now the site of a WHO/ UNICEF assisted bilharziasis pilot project — potentially the largest in the world; (BELOW) demonstration by a field technician on the use of a drag scoop. The scoop is a quantitative snail sampling device used at the new UAR project.

### BILHARZIASIS CONTROL (IRAQ, SUDAN, UAR).

Thorough studies on the epidemiology and control of bilharziasis have been carried out in the Gezira irrigation tract. A wide range of tests on ways to improve snail control methods, including the use of mechanical barriers and of copper sulphate bags, have been carried out in this area (BELOW).



In Iraq, as in the Sudan and UAR, snail control methods include the use of such mechanical barriers.

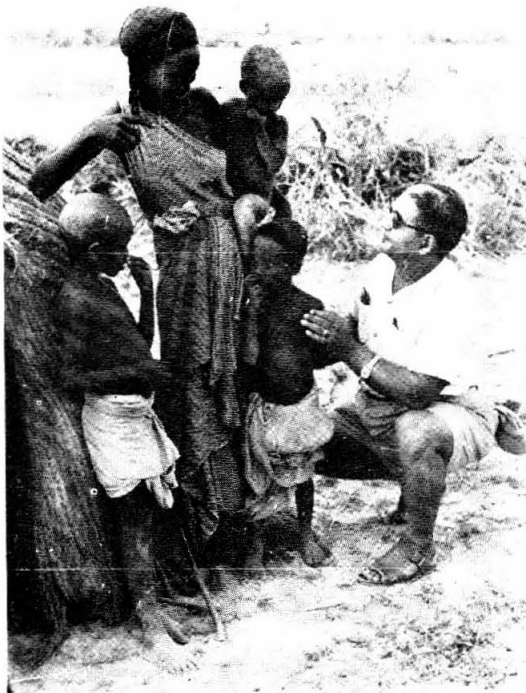


Building an *akhal*, the transportable thatched nomad hut.

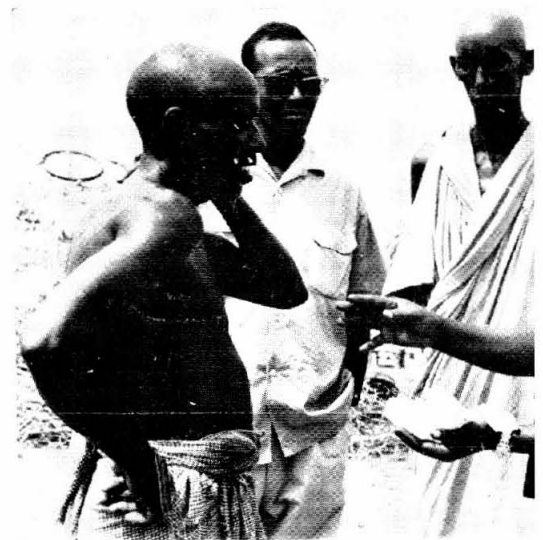


Somali nomads with their belongings in front of the nomad; make up almost two-thirds of the total numerous victims among the wandering tribes.

## MALARIA ERADICATION (SOMALIA)



This little nomad boy's enlarged spleen suggests repeated attacks of malaria. Further microscopic examination of a blood sample from this young "suspect" will show if he is a parasite carrier.



A Somali malariologist gives pyrethamine tablets to a man in an area at malaria risk. An emergency air-shipment of pyrethamine and chloroquine tablets was made to Mogadishu, last fall, to check malaria epidemics.



Investigations on "tough breeds" of mosquito arouse keen interest among villagers in the Kazeroun area. Double resistance by malaria-carrying mosquito *Anopheles stephensi* to both DDT and Dieldrin is a matter of special concern to Iranian malariologists. Field investigations in Iran's "problem area" include trials with new insecticides and medicated salt (generally chloroquine added to cooking salt).



An entomologist introduces mosquitoes into an exposure chamber to check the residual effect of the insecticide applied to this wall a month earlier.

## MALARIA ERADICATION (IRAN)

## TRACHOMA CONTROL TUNISIA & UAR



Deep in southern Tunisia, an ophthalmologist takes samples from suspected young cases for further bacteriological analysis in a laboratory.



In a number of UAR schools, senior pupils become experts at squeezing aureomycin ointment into their younger schoolmates' eyes.

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## CHOLERA CONTROL (PAKISTAN)

Survivors of a cyclone in Chittagong (East Pakistan) are given anti-cholera injections. The new "multi-dose hypodermic jet injector", which does away with the classical needle and syringe, can immunize as many as 1200 persons an hour safely and painlessly with any known vaccine.



91. A typical cross-section of the population in the experimental area of the project has been examined to obtain specific age and sex prevalence. Villages situated on main drains showed significantly higher infection rates. Continued attention has been paid to studies on population dynamics of snails. An important general conclusion resulting from the work is that growth and mortality are more rapid than had previously been supposed. The effect of these will be to reduce estimate of the length of a generation, and make it likely that recovery from mollusciciding will be more rapid than had been estimated. Field surveying and mapping of the irrigation and drainage systems, as well as hydrological conditions, and meteorological information in relation to bilharziasis are being given special attention. Sanitary surveys of villages are undertaken in connexion with the epidemiological and control studies.

92. The short-term and long-term objectives of the health education programme are being followed in the projects in the Region with the assistance of the Health Education Sections of the Ministries of Health. The final objective, integration of the control of the disease into the basic health services, is being studied to ascertain the best methods and techniques that would ensure future success.

93. Surveys of the disease have been carried out in Tunisia. It is present in the Nefzaoua area in the central region covering the districts of Kebili and Douz. A fellowship will be awarded by the Regional Office in July 1962 to train a sanitarian of the Tunisian Health Service to conduct control measures. Eradication of the disease in these oases is judged to be possible.

94. A comprehensive plan of action for the whole Region is being considered. Ethiopia, Iran, Iraq, Lebanon, Libya, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Republic and Yemen are included. Moreover, the Regional Office was represented at the Ciba Foundation Symposium on Bilharziasis held in Cairo from 17-23 March 1962, and at the conference held

in Cairo from 3-8 May 1962, to celebrate the centenary of Dr. Theodor Maximilian Bilharz, the discoverer of Schistosoma haematobium in the School of Medicine of Cairo in 1850.

95. Bilharziasis is assuming great importance on account of its progressive spread hand in hand with agricultural extension in the various countries, which is causing aggregation of hitherto dispersed communities and bringing them in contact with infective foci present in water courses. The wide prevalence of bilharziasis in this Region urges more action which it is hoped will be extended in coming years with the assistance of Governments, WHO and UNICEF.

#### SMALLPOX

96. From the table on page 60 it may be seen that, apart from West Pakistan there has been a marked decrease in smallpox in the Region, following in most cases mass vaccination campaigns. During the period under review, no smallpox cases were reported in Aden Colony, Aden Protectorate, Bahrein, Cyprus, French Somaliland, Iraq, Jordan, Kuwait, Lebanon, Qatar, Saudi Arabia, Syrian Arab Republic, United Arab Republic.

97. In Ethiopia, between early 1961 and May 1962, 900,000 persons were vaccinated during the combined yellow fever and smallpox vaccination campaigns undertaken in the south-western provinces of Ethiopia. The vaccinations are continuing and are being expanded systematically, for smallpox is still a serious problem in the country.

98. Ethiopia in 1961 established a department in its central reference laboratory (Institut Pasteur d'Ethiopie), for the production of lyophilized smallpox vaccine. The vaccine is produced in sufficient quantities. This is the main step towards the implementation of mass vaccination campaigns in dry and remote areas, together with the development of the basic public health services.

99. Libya is about to launch a smallpox eradication campaign in her territory and to that end has requested the assistance of UNICEF for the supply of vehicles which are needed for the vaccination of the population in remote areas.

100. In East Pakistan where smallpox is endemic, a pilot project for smallpox eradication was launched in the districts of Faridpur and Comilla (Dacca Division) in January 1961 and by November 1961, 85% of the 7.5 million population of these two districts had been vaccinated. No case of smallpox has been reported from either district since the first half of 1961. Five million doses of lyophilized vaccine donated by the USSR Government to WHO were used in this campaign. The Government requested WHO assistance in establishing a pilot project in the district of Kushtia (Rajshahi Province), which will be extended over the whole territory, so that by the end of 1963 the entire population of East Pakistan will be vaccinated.

101. A WHO consultant visited Pakistan from 23 July to 11 September 1961 to assist the Government in the production of lyophilized smallpox vaccine at Dacca. The results of potency and purity tests of the samples of the vaccine produced in the Dacca Pasteur Cum-Vaccine Institute, which have been sent to Copenhagen Staatserum Institute for testing were found satisfactory. The present output is of about 1,200,000 doses a week which can be easily raised to 2,000,000. At a week's notice, 1,600,000 doses were supplied to the West Pakistan Government for the vaccination campaign in the province, where smallpox had broken out in an epidemic form. At present, there are three freeze-dried units in operation. No supply of vaccine for the campaign is therefore necessary from outside the country.

102. In Saudi Arabia, smallpox is endemic. Plans are being made to include the production of lymph vaccine within the Central Public Health Laboratory at Riyadh, which is being established with the assistance of WHO. A general vaccination campaign started two years ago. From September 1960 to September 1961, 458,265 persons were vaccinated. General vaccination is

carried out every year two months before the pilgrimage season in the main towns visited by the pilgrims, viz. Mecca, Djeddah and Medina. At the present time, all persons arriving from the southern part of the country or from adjacent countries lying south, are vaccinated even if they are in possession of a valid international certificate. Two posts have also been established in the eastern region for the vaccination of pilgrims arriving by land via the Arabian Sea. No smallpox case has occurred in the Kingdom since the end of April 1961. An eradication campaign in 1963 will start with WHO's assistance.

103. In Somalia, smallpox is not an endemic disease, but there is constant danger due to movement of population from Ethiopia, Kenya and the Yemen. Teams of vaccinators are being organized and trained. The health personnel from Mogadishu were sent on a mass vaccination campaign to Upper Giuba and over 8,000 persons were vaccinated. UNICEF is providing vehicles for the health services. The smallpox eradication campaign is faced with many difficulties, because of the vastness of the area, lack of communications and the large nomadic population.

104. In Sudan, a plan of operation for the eradication of smallpox over a period of four years has been signed. The country has been divided into four zones and each year a complete zone will be vaccinated. The first phase of the campaign, which is to cover the Provinces of Kordofan and Darfur, with a population estimated to be three and a half million, started in January 1962. The total number of persons vaccinated by the end of May was: 3,044,950, of whom 1,500,435 were in Kordofan and 1,544,515 in Darfur Province. The take and success in primary vaccination was about 95% and that in secondary vaccination about 85%. For technical reasons, the freeze-dried apparatus supplied by WHO has not so far been able to produce vaccine.

105. Yemen was visited by the WHO Public Health Adviser and Country Representative for Saudi Arabia in February 1961, who studied the situation with a view to launching a smallpox eradication campaign throughout the territory.

A plan of operation has been signed for the mass vaccination, with WHO assistance, of the entire population within three years.

106. In Muscat and Oman, a mass vaccination was performed following the occurrence of eight cases of smallpox in Masna area, and over 70,000 were vaccinated in Dubai in the Trucial States as a result of twelve cases being reported early in 1962. Cyprus and Lebanon were supplied with vaccine which was donated by the Jordan Government to WHO, in order to assist their mass campaigns.

#### YELLOW FEVER

107. In view of the yellow fever outbreaks in Ethiopia at the end of 1959, and in 1960, when the deaths amounted to an estimated 3,000, the Government of Ethiopia and WHO took action. A team from the Pasteur Institute in Addis Ababa had identified the disease after the first outbreak and precautionary measures were taken to prevent its spread.

108. In October 1961, an Informal International Meeting of Experts on Yellow Fever was held and it was recommended that (1) entomological and zoological investigations should be made by capturing, identifying and inoculating into mice different species of mosquitoes from the area; (2) an epidemiological survey should be undertaken to check whether yellow fever was penetrating the mountain barrier in the East of Ethiopia and entering the Rift Valley (Kenya); to check whether yellow fever had penetrated into and become established in the forest of the Kaffa region; to determine whether yellow fever had penetrated the valley of the Baro river, a heavily populated valley near the Sudan border.

109. A team from the Pasteur Institute of Ethiopia, under the leadership of Dr. Ch. Sérié, including an entomologist and a veterinary officer was set up to carry out these recommendations, and WHO allocated \$30,000 from the Research Fund for the purpose. The epidemiological survey was carried out from 14 November 1961 to 24 February 1962. The area was divided into five sectors, which were successively visited by the team. The team

collected 1,100 sera for the study not only of yellow fever virus but also of virus arbor, and concluded that an epidemic foyer existed south-west of Djimma, in the Coulo-Conta, that the Baro-Chilo-Didessa zone might be considered an endemic area. Three human viral strains isolated from sick persons and sent to the various laboratories for identification have so far been confirmed as yellow fever strains by the Rockefeller Institute, New York.

110. After its tour in Kaffa Province, where the survey carried out ten years before had revealed no signs of yellow fever, the team established an experimental station for entomological investigations in Tchabera area, south-east of Gimma, where the presence of numerous Aedes simpsoni had been noted during the human epidemic. Twelve viral strains were isolated from Aedes simpsoni and dispatched for identification to various laboratories abroad in addition to Addis Ababa. Eight of these were identified as yellow fever virus. The proof of Aedes simpsoni being a yellow fever vector is now definitely established, and an important number of domestic animal sera were found positive.

111. In January 1962, while the survey was in progress in Kaffa Province, a new alarm arose. Information was received that some one hundred deaths had been reported from the Tirog area, Illoubabor Province, in Ethiopia, near Akobo, fifteen miles from the Sudan border. The Ethiopian Government sent a team to investigate into the nature of the disease responsible for the reported cases of deaths. However, because of Tirog region being inaccessible, the area being out of reach even by helicopter, the results of the investigations are so far not known. In the meantime, all precautionary measures have been taken including the inoculation of 300,000 persons. The question of yellow fever in the western part of Ethiopia and the region bordering the Sudan is being given much attention by WHO Headquarters.

COMMUNICABLE EYE DISEASES

112. Trachoma and related eye diseases are still widespread in the countries of the Eastern Mediterranean Region. Control projects have been planned and launched since 1952 in Tunisia and in the United Arab Republic, they are still in operation and have produced encouraging results. Since then, many countries of our Region are becoming increasingly interested in establishing trachoma control projects.

113. At the beginning of 1961, a WHO-assisted communicable eye diseases control project was put into operation in Iraq. It has been successfully developed and is going to be extended very soon from Baghdad town and liwa to other parts of the country. Similar projects have been planned for 1961 in Jordan, in West Pakistan, and in the Sudan.

114. Projects on a national basis have been successfully developed in Eritrea, Ethiopia, where school children have been under regular control for several years and total population groups have been covered by treatment campaigns. Trachoma control measures are being applied in Iran, and in Tripolitania, Libya, particularly to school children. The Government of Kuwait has also indicated their interest in starting a campaign in all schools of the country.

115. The WHO-assisted virological research unit at the Ophthalmological Centre in Tunis has succeeded in isolating various trachoma virus strains from trachoma patients. It also carries out laboratory screening of antibiotics and other drugs searching for more effective methods of treatment. A similar laboratory is in operation on a national basis in Asmara.

116. Prospects of Trachoma Control. Although it is not fatal, trachoma and co-related diseases cause substantial economic loss in manpower and working hours in the Eastern Mediterranean Region.

117. The efficacy of trachoma control measures applied in a campaign widely depends on their being comprehensive and complete. Fortunately it is

possible in our days to cure trachoma infected persons by means of anti-biotics or long acting sulpha drugs. But in a mass campaign, it is not sufficient to rely upon the efficacy of medicaments only as a single method of treatment, since in the field too many conditions are involved, favouring trachoma infection. Additional means of access are required in a mass campaign to combat the disease. These means might even be of a higher fundamental importance than the therapeutic measures applied.

118. Consequently, the success of a trachoma control campaign largely depends on the proper and energetic application of measures for improving sanitation and the social and educational standards of the people. This can best be achieved by integrating trachoma control into the general public health and sanitary services of a country. It might be of interest in this context to recall the fact that trachoma, at the beginning of this century, was still prevalent in various parts of Western and Central Europe, but without any specific treatment being applied it diminished as the standard of living and hygiene rose, with the result that today even eye specialists there often know trachoma only by name.

119. Celebration of World Health Day 1962. The fourteenth anniversary of the coming into force of the Constitution of the World Health Organization was devoted to the theme "The Prevention of Blindness". The attention of Governments, health administrations and the people was drawn to the enormous amount of blindness in the world and to the fact that two-thirds of it could be prevented, if the necessary treatment were available at the right time and in the right place.

#### LEPROSY

120. The most important development in this field was the EURO/EMRO Inter-Regional Leprosy Conference held in Istanbul from 2-7 October, 1961, at which Cyprus, Iran and Lebanon were represented.

121. Following is a summary of some of the highlights of the discussions and the recommendations: (1) It is not possible to determine prevalence

with any accuracy until surveys have been made on the basis of either a sample of the total population, or the total population in a given zone.

(2) A leprosy control campaign should begin in a pilot project in a zone of high prevalence in relation to that estimated on an average for the

country. (3) Case-finding should be followed by treatment of detected

cases. (4) Ambulatory treatment may be given in an out-patient clinic, health centre, or rural medical station, or by mobile units; treatment

must be continuous and regular during the prescribed period (at least two years in lepromatous cases). (5) Building of new sanatoria is not recom-

mended, and those existing should be modernized. (6) Where health condi-

tions are sufficiently good, mass campaigns are unnecessary. (7) Clinical and bacteriological examinations must be effected at least once a year.

(8) Prolonged chemoprophylaxis of child-contacts is effective in reducing incidence of the disease; BCG vaccination in areas where leprosy is present

cannot be other than advantageous. (9) Early diagnosis and regular treat-

ment of the first stages of leprosy will prevent invalidism and disability, and hence the need for expensive programmes of rehabilitation. (10) All

legislation and regulations relating to the control, prophylaxis and treat-

ment of communicable diseases in general should apply automatically to leprosy. Any existing legislation contrary to this principle should be

repealed. (11) Legal enforcement of compulsory isolation in leproseries has serious disadvantages and is an obstacle to the development of a leprosy

control campaign. (12) The separation of children from their leprous parents is not recommended. (13) Education of the entire society must be

continuous and intensive, to break down universal prejudice against the disease. (14) Attention must always be paid to the necessary social and occupational rehabilitation of the patient, but the final aim must be his

reintegration in the community.

122. Leprosy surveys were carried out in Cyprus, Iran and Lebanon during the latter part of 1961 by a WHO consultant. A leprosy control project is underway in Pakistan where a leprosy treatment centre was opened in January

this year. By the end of the first quarter 200 patients had registered. A short-term consultant is expected to visit the United Arab Republic before the end of the year in connexion with a leprosy control programme.

## EPIDEMIOLOGICAL SECTION

### EMRO'S EPIDEMIOLOGICAL INTELLIGENCE SYSTEM

123. In administering the International Sanitary Regulations, the World Health Organization, until 1 July 1961, had used the services of the quarantine units in the WHO Regions for the Americas, the Eastern Mediterranean, South-East Asia and the Western Pacific. The responsibilities of these three units in assisting the Director-General to administer the Regulations have now been transferred to WHO Headquarters, Geneva.

124. To avoid disruption of service, the change-over was made in two stages. On 1 July 1961, responsibilities other than those under Articles 3 to 7, 9 and parts of 11 of the International Sanitary Regulations were transferred to Headquarters, but for six months States continued to send the notifications required by these articles to the Quarantine Unit in Alexandria, which maintained its responsibility for receiving and disseminating them. All other notifications and questions or complaints were addressed directly to Geneva. On 1 January 1962, the transition period came to an end, and all notifications from then on were sent directly to Headquarters in Geneva and consequently, except for transmitting to Headquarters information which some countries of the Region continued in error to address to the Regional Office, the activity of the Alexandria Quarantine Unit virtually ceased.

125. As a result of the new arrangements, the publishing of the Weekly Epidemiological Bulletin which was printed in 250 copies was discontinued after its last issue of 29 December 1961. As for the bi-weekly radio broadcast on 1 January 1962, at the request of Headquarters and as a temporary measure, Radio Cairo started retransmitting on Wednesdays and Fridays at 12.15 GMT the contents of Headquarters' daily epidemiological radio-bulletin.

126. International Sanitary Regulations. During the period under review, the Arabic version of the 1961 Annotated edition of the International Sanitary Regulations was printed and distributed to the interested countries.

127. Summary of Outbreaks of Quarantinable Diseases of Special Interest. The major epidemics with which the countries of the Region had to deal were the smallpox epidemic in Karachi area and the yellow fever outbreaks in Ethiopia.

128. Cholera in Pakistan. Since the epidemic which broke out in West Pakistan on 21 May 1960 and ended on 17 December of that year, no cholera case has been reported from that province. There was a considerable decline of cholera incidence in East Pakistan throughout 1961; 1,279 cases were reported during the year as against 8,301 in 1960 and 20,035 in 1959. However, a rise in the incidence is reported during the first four four-weekly periods of 1962 as compared with 1961.

Cholera in East Pakistan

Four-Weekly Periods	1959	1960	1961	1962
J I	1,286	1,481	141	313
F II	756	398	32	151
M III	611	487	52	181
A IV	1,103	2,686	68	475
M V	1,371	1,670	26	
J VI	227	297	12	
J VII	85	80	11	
J VIII	105	92	109	
A IX	235	47	36	
S X	1,532	19	36	
O XI	4,728	120	51	
N XII	4,813	456	256	
D XIII	3,183	468	449	
	20,035	8,301	1,279	

129. In this connexion, it will be noted that outside the classical cholera foyers (India, East Pakistan), epidemics of paracholera El-Tor, which for some decades had been limited to the Celebes, were reported during the period under review, in several countries of the Western Pacific. Following the appearance of these epidemics, a WHO meeting was convened in Manila in April to study this recent spread of paracholera El-Tor vibrio. It was attended by a representative from Pakistan. The Committee on International Quarantine at Headquarters, which met in Geneva on 3 May 1962, considered the question of El-Tor infection and its relationship to the International Sanitary Regulations. The Committee expressed the opinion that cholera, under the definition of quarantinable diseases in Article 1 of the Regulations, should include cholera due to the El-Tor vibrio. This opinion was endorsed by the Fifteenth World Health Assembly on 23 May 1962.

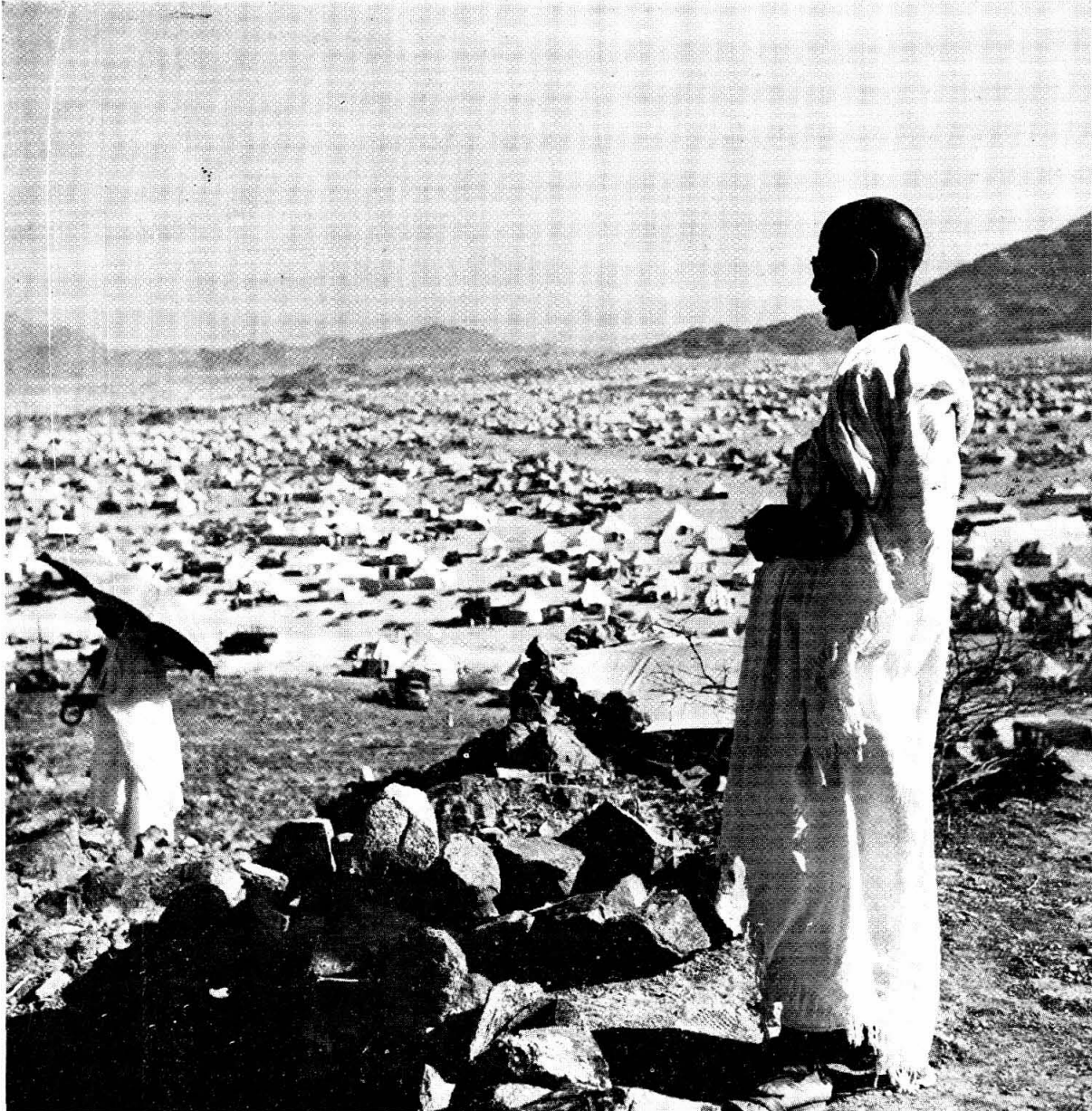
130. Smallpox Incidence in the Region. The following table shows totals of smallpox cases reported during the period under review as compared to the totals of the preceding period.

Countries	July 1960 to June 1961	July 1961 to date Indicated	
Aden Colony	1(1)	0	To 2 June 1962
Aden Protectorate	1	0	To 2 June 1962
Ethiopia	814	321	To 16 June 1962
Iran	264	108	To 31 March 1962
Muscat and Oman (Masna area)	0	8	
Pakistan			
East	532	412 )	Approximate figures to 26 May 1962
West	1,167	1,394 )	
Karachi	158	1,899 )	
Saudi Arabia	38	0	
Sudan	108(1)	10	To 13 June 1962
Trucial States			
Dubai	0	12	
Fujairah, Sheikdom	0	1(1)	
Yemen	D	D	

( ) Figures within brackets are imported cases and are included in the total

D Data not available

## MECCA PILGRIMAGE (SAUDI ARABIA)



The Plain of Arafat teems with tents on the ninth day of the Pilgrimage month. For a few hours the barren expanse comes to life as the faithful wait from dawn to sunset in the final ceremony of the hadj. The 1381 (1962) Pilgrimage was free from quarantinable diseases. A further sharp drop in fatalities from heat prostration was recorded this year: during the four-day rituals, heat accounted for 57 deaths, as against 194 last year, 377 in 1960 and 454 in 1959.

MATERNITY & CHILD HEALTH  
TRAINING CENTRE

اولاد و تہذیب و صحت مرکز



MCH TRAINING CENTRE,  
KARACHI (PAKISTAN)

Periodic medical check-ups of children are carried out at the MCH centre. They may show clinical signs of nutritional deficiencies.



The Karachi MCH training centre last year had more than 50 applicants, from whom 32 were selected — compared with 8 applicants in 1956, when the centre was opened. Other schools in Pakistan also reported a marked increase in enrolment.



Student nurses and a nursing instructor from the Karachi MCH centre visit a recently confined young woman.

131. Saudi Arabia agreed that, during the season of periodic mass congregations, arrivals revaccinated against cholera after having previously received two cholera injections would not be required to show more than one injection, if their revaccination took place before the expiry of the validity of their certificate and was not more than six months old.

## PUBLIC HEALTH SERVICES

### HEALTH EDUCATION

132. Health education has received particular attention in WHO-assisted field projects, conferences and training programmes in the Region. At the Inter-Regional Technical Meeting on Malaria Eradication in Teheran in May 1962, reference was made to "human resistance" to the diagnosis of malaria, through ignorance of the intensity of the problem, and the need for health education programmes involving every stratum of the community and every level of society was stressed. Another indication of the general awareness in the Region of the importance of the subject was the holding in Cairo in January of a Health Education Conference convened by the Ministry of Health, United Arab Republic, where 400 participants discussed many aspects of the problem, and made recommendations for accelerated action.

133. It is felt very strongly that health education should not be considered as a separate subject but should be introduced naturally with other activities and by suggestion rather than compulsion. WHO staff in nutrition, maternal and child health, nursing, environmental sanitation and communicable disease control or eradication projects are directed to promote health education in their daily contact with the people. It is recommended that all schools, health training centres, institutes and medical colleges should include the subject in their curricula, and to further the teaching, fellowships are needed to train national staff in health education philosophy and methods. Care should be taken to use the techniques applicable to each country or

area and supporting audio-visual material should in both content and language be adapted to local conditions.

134. A WHO health education consultant was assigned in 1962 for three months to the High Institute of Public Health, Alexandria. During her tour of duty she participated in joint planning between the Health Education Section of the Institute and the Ministry of Health, and assisted with the drafting of the Five-Year Plan for this Section. She also contributed to the Conference at the Higher Institute of Nursing, where health education in the nursing curriculum was discussed. The WHO Public Health Adviser assigned to the Arab States Centre for Education in Community Development has continued to teach public health principles in the various phases of the training programme, including public health administration and health education. His assignment is expected to continue for the next two years.

135. A new development is that the health education programme of UNRWA, whose health service is under the technical direction of WHO, is being modified to cover all the Agency's fields of activity. More use is to be made of organized groups and means of mass communication. Health Committees for this purpose are being organized in each refugee camp and in nearly all schools.

136. A study, based on documents available in the Regional Office, has been made this year to determine the development of health education in the Region.\* Apart from the gradual progress in the acceptance of health education as a service urgently needed in promoting health conditions, which may be noted, there has been a growing awareness, even though slow at times, of the type of services a specialist in health education can render. The number of requests from Governments for fellowship awards in health education is indicative of this fact. It is felt, however, that more research into the status of health education in the Region is needed.

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\* See: Annex II

137. The present Regional Health Education Adviser is following up the work already accomplished by his predecessor who is on study leave. He will, upon request, advise Governments on their health education programmes.

#### HEALTH LABORATORIES AND RELATED SERVICES

138. More and more countries in the Region are requesting assistance for the reorganization and development of public health laboratory and related services within the frame of their health services. Specialized advisers and consultants, supplies and equipment, have been provided either from Government funds or by WHO on behalf of Governments on a reimburseable basis. Examples of assistance to projects of this kind provided by WHO on request are: virologists for Iraq, Jordan and the United Arab Republic; a short-term consultant bacteriologist for the Public Health Institute in Dacca, East Pakistan; a public health adviser for the establishment of a Central Public Health Laboratory at Islamabad, West Pakistan; a bacteriologist and a laboratory technician for the Central Public Health Laboratory in Riyadh, Saudi Arabia, and an adviser for concentrated sera production in the United Arab Republic. Blood bank services have been requested by Iraq, Lebanon, Somalia and the Syrian Arab Republic.

139. A WHO expert in public health laboratory architecture will visit the Sudan shortly to advise the Government on the plans for their new laboratory. A WHO consultant visited Lebanon, Iraq and the Sudan to advise on the future plans to improve drug control measures. In Somalia, preparations are underway to assign an expert for the organization and management of medical stores and supplies.

140. Provision is made for the establishment of a Regional training course for laboratory technicians in Beirut which is expected to start in 1962. Assistance for the improvement of national training facilities as well as for training abroad through fellowship awards, has been maintained.

MATERNAL AND CHILD HEALTH

111. WHO assistance to maternal and child health activities which are an integral part of more generalized health and training projects continued in Ethiopia, Lebanon, Libya, Somalia, Sudan, Syrian Arab Republic, United Arab Republic and Yemen.

112. At the Maternal and Child Health Demonstration and Training Centre, Benghazi, Cyrenaica, the third group of maternal and child health auxiliaries is at present in training while the second group of graduates have been appointed mainly in the hospital services.

113. At the Maternal and Child Health Demonstration and Training Centre in Tunisia, a closer liaison with children's and maternity hospitals as well as with the general health services is attempted, but no specialized maternal and child health auxiliaries are being trained. The Centre has so far served for refresher or orientation courses in maternal and child care for health personnel already engaged or who will be engaged in maternal and child health activities. Meanwhile plans are being made for incorporating theoretical and practical teaching in maternal and child care into the training of nurses, midwives and nursing auxiliaries at the Ecole Avicenne in Tunis.

114. WHO assistance to the Children's Hospital, Karachi, was terminated at the end of 1961. Training programmes for medical students, general practitioners, nurses, nurse trainees and lady health visitor trainees have been established. A preventive section at the out-patient department has also been organized for the follow-up of children discharged from the hospital and for the education of the mothers. A few months after this was established the accommodation pressure on the paediatric wards was relieved.

115. At the Children's Hospital, Amman, the WHO nurse has assisted in organizing the training in paediatric nursing of nurses, nurse trainees, auxiliary nurses, community (MCH) midwives and community midwife trainees. She is also assisting in bringing about some of the required coordination

of activities at the Children's Hospital, the Maternal and Child Health Demonstration and Training Centre (previously WHO-assisted), the School of Nursing, the Maternity Hospital, the domiciliary midwifery and other programmes. A preventive and follow-up section is being organized at the out-patient clinic.

146. The activities of the WHO Visiting Professor of Social Paediatrics who assisted the national staff of the Maternal and Child Health Department at the High Institute of Public Health, Alexandria, United Arab Republic, in drawing up courses in maternal and child health and school health were terminated in August 1961. It is hoped that preventive maternal and child health facilities which are well integrated with the curative ones will be available for the practical training which should supplement the theoretical training in the future.

147. Maternal and child health projects in which WHO assistance has been withdrawn were followed up as in previous years, and constant touch is kept with the national health personnel concerned.

#### FUTURE TRENDS

148. In 1957 the Regional Office sponsored an Inter-Regional Maternal and Child Health Seminar for the Eastern Mediterranean Region and adjacent countries. A summary of the recommendations of this Seminar were included in the Annual Report of the Regional Director to the Regional Committee at its Eighth Session in 1958.\* Although serious attempts have been made during the past five years to implement these recommendations, progress has been slow and much remains to be done. Future efforts should be concentrated more on: (1) Obtaining accurate national data on birth rates, infant (0-1 year), child (1-4 years), and maternal mortality rates, as well as on morbidity rates and causes of death. (2) Integrating, wherever possible, the school health and the maternal and child health services into the total

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\* Document EM/RC8/2, paras.101-102

health programme at all levels.\* (3) Improving the quantity and quality of child health and hospital facilities. (4) Increasing the use of local products to obviate the necessity for imported milk distribution. (5) Stimulating a closer liaison between the University and the Ministry of Public Health, so that the teaching of medical students could be adapted to present needs especially in the field of social paediatrics, public health and maternal and child health. (6) Adopting measures to diminish the risk of diarrhoeal diseases in the young child which will diminish the risk of malnutrition including the convening of meetings and seminars on this disease complex as a follow-up to the first Maternal and Child Health Seminar. (7) Improving the knowledge of practising physicians in child care (social paediatrics) and nutrition through strengthening of paediatric departments at medical schools in proportion to the development and to the standard of other departments in the medical school, especially preventive medicine, as well as to the development of local health services in the country, and to the standard of performance in children's hospitals.

149. WHO assistance in the organization and functioning of maternal and child health projects began systematically in this Region about ten years ago. Based on the experience gained the trends in the next ten years may now be more easily predicted and planned, while the concept of a maternal and child health service which is adapted to the Eastern Mediterranean Region can be more clearly defined.

150. One of the most important goals to be reached over the next ten years is to overcome the tendency to consider "Maternal and Child Health" as a separate entity from hospital services for women and children on the one hand, and from the general health service for the family on the other. Preventive maternal and child health activities should wherever possible be gradually introduced into all out-patient departments of hospitals where facilities for women and children are available, even in the smallest rural hospital.

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\* Documents EM/RC10/2, paras.185-188 and EM/RC11/2, paras.109-112

151. A model maternal and child health demonstration and training unit to be complete and of maximum effectiveness should consist of the following components working closely together: (1) A children's hospital, or a children's ward in a general hospital. (2) A maternity hospital or a maternity ward in a general hospital. (3) An out-patient department service, including a preventive and follow-up section for mothers and children - and wherever possible for the family as a whole - covering pre-natal, post-natal, infant and child curative and preventive care, a domiciliary midwifery and a home visiting programme. At least during the summer months rehabilitation activities for diarrhoeal diseases and infant feeding cases, fluid electrolyte and nutritional therapy and advice, need to be actively carried out at the child health section of the out-patient department, and followed up in the home.

152. This merging of maternal and child health activities with hospital out-patient departments (or with health centres for the family) will at the same time help in solving the problem of shortage of personnel and of financial resources required for the running of two separate organizations.

153. Even in a demonstration maternal and child health unit the building, furniture and equipment though adequate should be simple and possible to duplicate in other parts of the country, and wherever feasible should be based on local architectural and cultural patterns.

154. A reorganization of the existing children's hospitals or wards to include, for instance, facilities for keeping the mother with the child ("rooming in") and of out-patient departments aimed at amalgamating curative and preventive activities should be undertaken. Apart from being more economical this would facilitate follow-up and gradually reduce the number of recurrences and readmissions, especially of diarrhoeal and nutritional cases among children, and would relieve the overcrowding at the hospitals and clinics with cases which could have been prevented at an earlier stage.

155. Training of "MCH" personnel. Only a few of the points which should be kept in mind in planning future maternal and child health training programmes will be discussed here, as the subject was fully dealt with in last year's Report.\*

156. Institute of "MCH" or Child Health. Most countries in this Region should over the coming ten years aim at having such an institute for the training of health personnel concerned with the health of women and children. The prerequisites for the organization of such an institute or training centre are: (1) A medical school where the departments of paediatrics, obstetrics and public health work closely together. (2) Post-graduate school of public health, with a maternal and child health department working closely with all other departments. (3) Nursing school, basic and post-basic. (4) Maternity and children's university hospitals (or wards), with an integrated preventive and curative maternal and child health service at the out-patient department, as mentioned under "Model maternal and child health unit". (5) A health centre (with a well run maternal and child health section) both urban and rural covering a community health service at the disposal of the institute.

157. For the success of this scheme it is essential that the medical school, the health department, school of public health, nursing and midwifery school, school of auxiliary health personnel, maternity and children's hospitals, should work closely together, with constant interchange of service and teaching staff.

158. The institute of child health or maternal and child health should be used for the training in paediatrics, obstetrics, public health, maternal and child health, as an integral part of general health and of public health nursing, of the following categories: (a) Students of medicine, nursing and midwifery, as well as auxiliary health trainees. (b) Post-graduate physicians. (c) Post-graduates in nursing, and auxiliary health personnel.

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\* Document EM/RC11/2, paras.96-105

159. Short orientation or refresher courses should also be given for physicians, nurses, midwives and auxiliaries who are employed in the general health and maternal and child health service including general physicians employed in outlying small general hospitals where no specialists are available. The great majority of children seen in private practice or at health centres, maternal and child health centres, and at dispensaries, are the responsibility of general practitioners with only a basic medical training.

160. Regional Institute of Child Health (MCH). Consideration should also be given to developing one or more of the national institutes of child health or "MCH" into a regional institute to be used for the training of health personnel from the countries or from a group of countries of this Region, especially from those countries in which the organization of such an institute on a national level would be delayed due to various difficulties. It is to be stressed that such a regional centre should wherever possible be part of a more comprehensive general health institute or training centre, as this would be more economical and more sound.

161. The regional institute should work closely with similar maternal and child health or child health institutes abroad which are used for the training of health personnel from this Region, either through WHO and other fellowships, or privately. On their return from training abroad health personnel need to spend at least three months at the regional institute and the attached model maternal and child health unit described above, in order to reorient themselves on health conditions and problems which prevail in the area. An exchange of lecturers and health workers would assist both institutes to develop a realistic and effective training programme.

162. Apart from the need for organizing one regional institute to be used for training in all aspects of maternal and child health, certain countries should be used for short training or observation periods in special fields in which they can make a valuable contribution. For example, the integrated training in maternal and child health of the members of the health

team who will work in a rural area, especially health officers and community nurses, can be demonstrated at the Public Health College and Training Centre, Gondar, Ethiopia. Sudan has among other things a special contribution to make in the training of illiterate and semi-literate midwives, while in Aden Protectorate the "step by step" training of auxiliary health and nursing personnel and the stage at which a country is ready for the introduction of maternal and child health into the training and the service are of particular interest. The Health Centre and Training School, Sana'a, is a good example of a health project in which a maternal and child health service and training programme gradually branched out from a general health service in a country where there is an acute shortage of health personnel.

163. Research. Research activities, like the health service and training programmes, need to be directed more towards the major problems of health in the country itself.

164. The Regional Study on Diarrhoeal Diseases includes research which is being carried out by national paediatricians in children's hospitals in Addis Ababa, Amman and Karachi, and to be undertaken in several other hospitals shortly, using for the purpose a standard card specially designed at the Regional Office, covering social and economic factors as well as clinical findings. The information available on the completed cards will be processed at EMRO and it is expected that some interesting data will be obtained.

165. Infant feeding and weaning practices are closely related to the problem of diarrhoeal diseases, to nutritional status, anaemias and to mortality among infants and small children. It is now known that vegetable foods rich in proteins can maintain normal growth and development in young children. It is recommended that further research be carried out in each country on the availability and acceptability of these foods to the family, as well as on their toxicity, digestibility and palatability to the infant and young child.

166. Studies on methods of maintaining fluid and electrolyte balance, orally and parenterally, which are applicable to health conditions and health facilities in this Region are also important and should be included in the research plans of any country which seriously hopes to improve the health and to decrease mortality among infants and children.

167. A group meeting on the diarrhoeal diseases and related problems mentioned above is under consideration for 1965. Consultants will also be provided in 1963 and 1964 to stimulate, guide and coordinate research activities in this field, as well as collect and compile already available information.

168. Apart from the activities connected with the Regional Study on Diarrhoeal Diseases, assistance has been given to the Inter-Regional Diarrhoeal Diseases Advisory Team from Headquarters during their visit to the United Arab Republic in the summer of 1961 and in their preliminary visit to Iraq in February 1962. It is hoped that the regional and global approach to this complex problem will supplement each other for the benefit of child health in this as well as in other Regions.

#### NURSING

169. In assessing the development of health services, it is evident that nursing has continued to make commendable progress. This to a large degree reflects the awakening of women everywhere to the unique responsibility that is theirs to strengthen and support their growing nations. This developing dynamism is creating conflicts in respect of old concepts of women and her place in society; but conflict is the yeast that leavens endeavour and is therefore a healthy force.

170. There are at present twenty-four WHO-assisted projects in operation in which WHO nurses participate. In October 1961, Saudi Arabia started the first training programme for female nursing personnel. This was indeed a momentous occasion and will have far-reaching effects on the

administration of health services as well as on the social organization of the country. The programme, as yet in its initial stage, will need careful nurturing to survive. Our consultants feel however that if the sample of the female population that they met is representative, it will survive. The desire for knowledge has been kindled. Ways will be found to circumvent the difficulties.

171. In further consideration of achievement in the Region, Libya introduced a four-year training programme for nurses in lieu of the two-year auxiliary training programme. The Government have made extensive structural changes in the school to facilitate the work and allow for expansion. There is still need to supplement the basic general education of the students but there is a noticeable change in the calibre of young woman interested in nursing and a more selective process will be adopted for recruitment this year.

172. Progress in terms of increased enrolment of students is seen in almost every country of the Region. The Rey School of Nursing in Iran increased its enrolment by fifty per cent over the previous year and selected students from among the upper third of those finishing secondary school. The Higher Institute of Nursing, Alexandria, United Arab Republic, has twice the number of applicants it can enrol. All are qualified for University entrance. In the Yemen, graduates of the Health Training Centre, Sana'a, are making a marked impression on the services provided in the hospital and health centre and the school's enrolment has been doubled. The Khartoum College of Nursing, Sudan, which of all the schools established has probably the highest standard of nursing education, had sixteen applications when at the same time last year there were six. Three girls from neighbouring countries are enrolled.

173. Another significant indication of growth in nursing is the quality of the curricula. The integration of public health and the social aspects of nursing has become a reality in most countries and public health nurses are being engaged to teach in the basic programme. Schools of nursing are

dissatisfied with curricula 'borrowed' from other countries and are developing their own.

174. The Higher Institute of Nursing in Alexandria, in line with similar institutions throughout the world, is offering courses in introduction to research methods. In Cairo (Egypt 50) graduates, as student teachers and administrators, are applying this knowledge as they develop the most suitable pattern of nursing services administration and nursing education for the United Arab Republic.

175. The Institute, although not fully accomplishing its initial aim, which is also to provide other countries with first level nurse leaders, has nevertheless made a contribution that one day will be recognized to be of equal importance. It has demonstrated the meaning of professional nursing and helped many countries to realize that nurses must be educated if they are to carry their responsibility in the health team; that they must develop enquiring minds to understand what the physician wants to be done for his patients and at times to be able to take action in the absence of the physician; that if nursing is to progress nurses must have the knowledge and skill to conduct the affairs of nursing which include the provision of comprehensive nursing care and how to arrange for the education nurses require. It has also furthered the interpretation and coordination of health services and the processing of legislation to protect the public against malpractice in nursing. In this age of science nurses must be able to participate intelligently with doctors in doing medical research and with other disciplines, or alone be able to conduct research for the on-going development of their own profession. The Institute has also demonstrated that education which equips the young woman to practice and to think professionally is the best advertisement for recruitment.

176. Iraq, which offers equal opportunity of higher education to men and women, but has kept nursing on an auxiliary level, has realized the need for drastic change and plans to start a Higher Institute of Nursing as soon as

possible. The WHO Senior Adviser of the Alexandria Institute as a short-term consultant, has assisted the Government with their planning of the programme.

177. In planning further assistance to nursing in the Region it is necessary to differentiate between the levels of nursing development in the various countries. In a country where general education of women is just beginning it is considered advisable to wait until this phenomenon adjusts itself within the social structure before direct help to a specific project is attempted. However, expert advisory assistance is needed at Government level. Where education was introduced less than a decade ago planning must provide for both the service and training needs of the country for the next decade. In countries where nursing education is developing satisfactorily and service needs are beginning to be met, help must be given on a higher level, such as in preparing teachers, administrators and research workers within the country itself to ensure progressive development. It is in such countries that projects could be undertaken that might be shared by other countries at a similar stage of development. In respect of this, consideration is being given to the development of a post-basic college of nursing as an inter-country project. It is envisaged that such a project would eventually provide courses in all major areas; a "major area" is interpreted as being nursing education, administration of nursing services, and nursing research in either of these fields. These courses would together provide core curricula which would relate to whatever clinical specialty the student might wish to take.

178. It is proposed to start with one major area and one clinical specialty. For example, teaching in midwifery. As a suitable pattern evolves and increasing numbers of national staff are prepared, all clinical specialties in all major areas would be offered. Eventually this college would change from a certificate to a degree programme and post-graduate as well as post-basic courses would be given. This is a long-term project and requires that

fellowships provide adequate time for nurses of the host country to obtain degrees to prepare them to become members of the faculty.

179. There are decided areas in nursing which continue to receive too little attention and which adversely affect the whole course of nursing education and service. One area of weakness in most countries of the Region is the continued absence of a nursing section on the national level to advise the Government on matters pertaining to nursing; to establish policies, set standards and see that these are maintained. Increasingly the value of a stable nursing structure to the overall health services of a country is recognized, but without the guidance of a competent organization at national level nursing tends to represent an ant hill demonstrating much confused activity but little productive work. Some countries that have a Section do not have legislation or a means of registering nursing personnel.

180. Another area of weakness is in nursing services administration on the local level which, besides providing patient care, establishes the field for clinical learning of doctors, nurses and all paramedical personnel. Useful knowledge and skills cannot be properly assimilated unless what is to be learned is seen, felt, heard and practised in the clinical environment. Until this area is improved, learning can only develop in the realm of theory. The Organization is planning a hospital services administration project for Iraq which will have a doctor and a nurse skilled in administration. This is an important project and is expected to provide knowledge that can be utilized elsewhere.

181. Meanwhile there are tools which could be used that would help to change the picture; such tools as guides on the staffing of hospitals and public health services which have been prepared by consultants employed by the Organization. These and similar documents could be used as working papers for a five to six day study conference for doctors, nurses and others engaged in the administration of health services in each country. These could be planned and ad hoc consultants provided to travel from country to country to lead discussions and organize groups for action.

182. Many curricula in use need to be evaluated and nurse educators need to be helped to develop skills required to design meaningful curricula. Countries need direction in setting up courses for nurses who are filling important positions without adequate preparation.

183. These are but a few areas in nursing that require strengthening. Assistance may be given by short-term consultants working with national leaders. There is need to provide more comprehensive midwifery training programmes for most countries of the Region. The practice of training specialists in deliveries only is uneconomical when it is considered that through the medium of midwifery the nurse has such an excellent opportunity to promote health and teach prevention of disease through family care.

184. Assistance to nursing on the basic level will be required for some time in some of the countries but planning must go on to help others to consolidate the rapid gains they have made and to promote their activities to higher levels to equip them to take their rightful places in the International Council of Nursing.

#### PUBLIC HEALTH ADMINISTRATION

##### GENERAL

185. The keen interest shown by countries of this Region in the development of national public health services is becoming increasingly evident. Many countries have established long-term health plans for the re-organization and acceleration of their health services on the basis of priorities. Some of these countries are already embarking on their second or third long-term plans.

186. Although the concept of health in its relation to the social and economic factors has not hitherto been fully realized in some countries, nevertheless the Seminar on the Organization and Administration of Community Development Programmes in the Arab States which was held in Cairo in May 1962 and was attended by top-level members of the national Governments in Arab

States showed a lively interest in the coordination of health services in the overall socio-economic planning for development of basic community services. It is understood that, in some countries of the Region, special coordinating councils or boards for overall planning and promotion of community services are active. In this respect there seems to be a consensus of opinion favouring the de-centralization of basic services at provincial, district and local levels and the development of a system of local Governments so as to sponsor these services, and to stimulate public interest and participation in an effective manner.

187. Regional WHO advisers on planning and community development will be appointed in the near future to assist countries of the Region to develop their health plans within the context of socio-economic levels.

188. The re-organization of national public health administrations in most countries of the Region continued to develop with more emphasis on the preventive health services and the development of epidemiological and vital and health statistics services. In this connexion WHO has planned to provide public health advisers to Jordan, Kuwait and East Pakistan, and epidemiologists to Ethiopia and Somalia. This is additional to WHO Representatives in Ethiopia, Iraq, Pakistan, Saudi Arabia, Somalia and Yemen.

189. In Somalia, a WHO specialist in surgery and an anaesthetist have been assigned to assist the Government in the promotion of medical care, particularly in the field of surgery and in the training of staff.

190. In Saudi Arabia, an agreement is expected to be concluded between WHO and the Government for the establishment of a model provincial health organization project in the eastern zone of the country. WHO will assist in providing on a reimbursable basis, fourteen health experts for the project.

#### COMMUNITY DEVELOPMENT

191. The Regional Office's participation in community development continues to be mainly through the Arab States Training Centre for Education in Community

Development (ASEEC), Sirs-el-Layyan, United Arab Republic, the annual regional United Nations Inter-agency meetings, and the workshops, seminars, etc., held by the Economic Commission for Africa.

192. However, close cooperation is maintained between WHO project staff and United Nations community development advisers in various countries, and in the training of all types of personnel at WHO projects the health aspects of community development are taken into consideration. This is particularly so at the rural health projects. Three are in operation in Lebanon, the Syrian Arab Republic and the Sudan, and two are planned for Cyprus and Pakistan. In Ethiopia, the WHO Supervisory Team for Health Centres which is scheduled to begin work in September 1962 will contribute to community development activities. At the High Institute of Public Health, Alexandria, United Arab Republic, and the Health Training Centre, Benghazi, Libya, the principles of community development are included in the curricula. In July 1961, a WHO consultant visited Saudi Arabia to advise on the public health nursing aspects of community development.

193. The appointment of WHO advisers to such countries as Jordan, Kuwait and East Pakistan are all indicative of the intention of the Organization to associate community development more closely with health activities.

194. It has been proposed that the WHO basic health services project in Somalia should be coordinated with the UN-sponsored community development programme in Villabruzzi. In Yemen it has also been suggested that community development centres should be established around Sana'a and that graduates from the WHO-supported health centre and training school should contribute to the basic activities of the centres.

195. The Economic Commission for Africa has established a Standing Committee of Social Welfare and Community Development which held its first session in February this year, and the United Nations with the cooperation of the Government of the United Arab Republic and ASEEC organized in May a Seminar on the Organization and Administration of Community Development programmes in the Arab States. The Regional Office was represented at both.

196. Replies to the questionnaire on rural health and community development circulated to Governments in April last year have been analyzed in a document prepared at the Regional Office (EM/RCL2/9).

#### LOCAL HEALTH SERVICES

197. The drive towards the expansion of rural health services in countries of the Region is well maintained. The WHO-assisted rural health project in northern Lebanon, in Halba, has achieved progress in gaining more support, at central level by the formation of a Rural Technical Committee, and at local level by the creation of a Health Committee from among the local people. An annual budget has also been approved for the project, with a special allocation for environmental services. In-service training has been conducted.

198. In West Pakistan thirty rural health centres are expected to function by mid-1962 and thirty more by the end of 1962. Plans are being made for nine health centres to be established in East Pakistan by mid-1962 and fifteen more by mid-1963. Some of the centres will serve as teaching and demonstration units.

199. In the Sudan budgetary provision has been approved for the first year of the seven-year plan for the expansion of rural health units. The WHO/UNICEF-assisted Rural Health Demonstration Area project at El Huda has also come into operation.

200. In the Syrian Arab Republic the WHO-assisted rural health project has been coordinated with the United Nations-assisted community development project at Haman-el-Awamid.

201. In the United Arab Republic it is planned to establish 2,500 rural health centres in accordance with the country's five-year plan; the first group of 400 centres will be opened during July 1962, and 400 to 450 centres annually during the period of the plan.

202. Preparations are under way for the establishment of a health centre in Hodeida, Yemen, in 1962 with the assistance of WHO. The national staff for the centre will be recruited from graduates of the Health Centre and Training School, Sana'a, which is a WHO-assisted project.

### VITAL AND HEALTH STATISTICS

203. The scarcity or even lack of basic vital and health statistical information remains for the majority of countries of the Region a barrier for measuring health progress. This scarcity also continues to be felt in the planning and carrying out of efficient health programmes. Extensive and reliable data is a pre-requisite for the public health administrator in deciding upon priorities among a multitude of existing needs for new or expanded programmes for prevention of disease and restoration of health. Such data are needed also for comparing existing needs in the field of health with other competing needs for improving the standard of living of populations, particularly in the social and economic spheres.

204. Awareness of the need for quantitative measurement of health problems for planning and other purposes has been shown by the responsible health authorities of the countries of the Region, but efforts to develop a health statistical system demand by nature considerable time to show results. Positive steps to strengthen the statistical services of the Ministry of Health have lately been taken by several countries, and here the fellowship programme of WHO has shown its effects. Health statistical offices are increasingly being staffed by personnel, trained through the fellowship programme.

205. Recent advances in vital and health statistics in the Region comprise a comprehensive morbidity survey in the United Arab Republic, the introduction of birth and death registration in West Pakistan, the proposal for a decree for registration in Saudi Arabia, and a revised system of collection of morbidity statistics in the Syrian Arab Republic.

206. WHO is stimulating health statistical development. A meeting has been planned for 1963 with the purpose of bringing together health administrators and statisticians of the Region to evaluate the present position and future needs in vital and health statistics, to exchange information and to design future action in the various fields of health statistics on the basis of national and international experience.

207. WHO has also taken an active interest in assisting Member Governments to develop national health statistical services, and the Regional Office will continue to provide the services of advisers, and fellowships for statistical studies at universities and other educational centres, or for practical training in countries where the health administrations have ample statistical services. Statistical advisers have been provided since 1958 to the Ministry of Health of the Syrian Arab Republic, and to the Ministry of Health of Pakistan since January 1961. In the tuberculosis projects in Tunisia and Pakistan statistical advisers were included in the WHO staff. A total of 15 fellowships in health statistics were awarded during the year. 13 of these fellowships were for the training of statistical assistants at the International Statistical Education Centre in Beirut for the academic year 1961/1962.

208. The Regional Statistical Adviser has continued to assist in the planning and evaluation of projects and in rendering advice to countries. The Epidemiological and Statistical Centre, established at the Regional Office early in 1960 has processed and analyzed statistical material from several surveys including tuberculosis, communicable eye diseases, bilharziasis and diarrhoeal diseases. This Centre and the Regional Statistical Adviser are generally at the service of the countries of the Region.

209. In August 1961 the Arabic version of the International Statistical Classification of Diseases, Injuries and Causes of Death was distributed to all Arabic speaking countries. This document is now being studied in the various countries, and the results of these studies are awaited for further action.

HEALTH PROTECTION AND PROMOTION

CANCER CONTROL

210. Increasing interest is being shown in the problem of cancer by health authorities all over the world, and in the Eastern Mediterranean Region several countries are planning cancer control programmes at a national level. In order to facilitate the preparation and the extension of these national programmes a technical paper on "Problems of Cancer"\* was presented at the Eleventh Session of the Regional Committee. The Committee urged Governments to intensify their action against cancer and requested the Regional Director to assist them particularly in obtaining statistical and epidemiological data.\*\* As a consequence two cancer control projects are being planned: one in Khartoum, Sudan, the other in Damascus, Syrian Arab Republic. Three fellowships have also been granted during the year for training specialists in pathology and radiotherapy.

211. From the answers to the questionnaire sent to all Governments of the Region, records have been obtained of the existing or projected facilities for diagnosis and treatment of cancer and of the special epidemiology of the disease inherent in certain areas. During his visits in the Eastern Mediterranean countries the Regional Adviser was able to collect in the field complementary information and to give advice to cancer specialists and public health administrators. The recent ideas about cancer were disseminated through conferences given to the students in some medical schools. In addition, the Regional Adviser actively participated in a refresher course on cancer organized by the American University in Beirut.

212. A study of the use of radiotherapy and especially of cobaltotherapy for treatment of cancer in some countries of the Region was made jointly by the International Atomic Energy Agency and the Eastern Mediterranean

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\* EM/RC11/6

\*\* See also resolution EM/RC11/R.6 in document EM/RC11/17

Regional Office. As a consequence good cooperation was established between the two organizations in planning assistance to Member States.

213. It is suggested that the Regional programme might appropriately include: assistance to Governments through national cancer control projects, either new or extended, fellowships; assistance in organizing a regional training centre at the Cancer Institute of Teheran; a meeting of regional consultants to study the geographical distribution of the disease in the Region and to plan national or regional cancer control programmes.

#### ENVIRONMENTAL HEALTH

214. The wide scope of environmental sanitation and its influence on almost every aspect of health, not only in preventing disease but also in positively promoting comfort and well-being is not always apparent and thus the real strides made in that field are difficult to evaluate. A comparison between the development of specific aspects of environmental sanitation and parallel activities in the field of public health may show that considerable progress has been achieved. On the other hand, considering these achievements in the light of the vast environmental sanitation needs and the additional problems created in that field by the continued progress and development of our present world, they look insignificant and the road ahead appears rough indeed. This should be a challenge to us to adopt a more dynamic approach in working towards a better sanitary environment.

215. The many sides of environmental sanitation work and its implication in almost every phase of social development, does not always allow a natural and normal pattern of priorities to be followed. Very often activities not considered as first priority within the context of environmental sanitation as a whole should come in the front line owing to their relation to urgent socio-economic developments. Other considerations may also lead to the selective promotion of specific aspects of environmental sanitation which indirectly are expected to stimulate development of basic environmental

sanitation facilities. Change in any accepted priority should not mean bypassing the application and development of basic sanitary elements. These continue to be the foundation for the development and extension of a healthy environment and should attract our increased interest and efforts. This diversity and extension of environmental sanitation, and its broadening horizon, have been among the reasons for WHO changing the name to fit the comprehensive activities involved. "Environmental Health" is now the recognized term.

216. The community water supply programme needs continued stimulation and assistance. Emphasis is still placed on the institution or development of an appropriate organization for the planning, study, financing, construction, operation and maintenance of community water supply, as well as on the training of personnel to carry out the required phases of a programme.

217. Research, as in other fields of public health, is becoming an essential part of any activity concerned with environmental health and more attention should be given to it. A number of difficulties not only on the technical side of the problems faced but also on their social aspects require research work to find the answer and the best approach.

218. Air pollution, water pollution, industrial wastes disposal with special reference to disposal of radioactive material, are among the new problems that the rapid progress of the developing countries are bringing to the forefront. They are gradually drawing our attention and interest.

219. It was repeatedly emphasized at the Conference on the "Social Aspects of Development Planning in the Arab States", held in Beirut in November 1961, that the main obstacle of development in some Arab countries is often not financial, but administrative, organizational and institutional. This is equally applicable in the development of environmental health work not only in certain Arab countries, but also in others of this Region. The comparatively recent involvement of the health department in broader environmental health responsibilities and activities is an additional handicap. The

recognition by the health authorities of their responsibilities in environmental health should go hand in hand with the development of an appropriate service to adequately undertake this task.

220. Training of sanitation personnel continues to be one of the basic requirements and will be so for a number of years. The first approach is to train elementary specialized workers. This phase is now evolving gradually to its second stage, that of training an intermediate and more specialized worker. Appropriate attention is also given when possible, to the training of higher qualified personnel in the field of environmental health and to giving to other health workers the basic knowledge they should have in that field.

221. In line with this concept, assistance and stimulation of activities in the development of environmental sanitation services within the Health Department, have continued in Lebanon, Pakistan and Saudi Arabia, and partly in the Syrian Arab Republic. A new project on this aspect has started in Tunisia. Training courses for sanitary aides are in full development in Ethiopia, Iraq, Saudi Arabia, the Syrian Arab Republic and Yemen, and new courses are being planned for Iran, Lebanon and Tunisia. A regional course for advanced training of sanitarians is under active study.

222. Although community water supply activities have made some headway, their development has been short of expectations. Only in Pakistan was the overall problem of community water supply reviewed by a WHO team of short-term consultants. A short course for waterworks design and operation was held in Lahore with the participation of Cyprus, Iran, Iraq, Jordan, Sudan, Syrian Arab Republic and the United Arab Republic, in addition to Pakistan. The purpose of the course was to refresh and widen the knowledge of personnel working in water supplies and stimulate interest for better results. Highly qualified specialists in the field of water supply have been provided by the Organization to West Pakistan and Jordan. A group meeting to review community water supply activities is planned to be held towards the end of 1962, and a short course for waterworks operators to take place soon is under study.

223. The first loan granted by the International Development Association to a water supply scheme was approved for Jordan in December 1961. However, this is the only one in this Region and represents but a very small fraction of the financial help that this field requires. It is considered that the possibilities and comparatively easy terms that this international loaning agency offers should be used to the maximum.

224. Housing and town planning, due to their socio-economic implications, is a problem of high priority and is also included in the Concerted Action Programme of United Nations and the Specialized Agencies.\* The first step taken in this field in the Region has been the recruitment of two experts who will survey in September 1962 the health aspects of housing in a few countries and will propose a programme for future approach and action. Co-operation and participation in the programme of Concerted International Action, on Housing and Related Community Facilities\* is maintained, especially for every activity concerning more particularly our Region. In this respect, participation of countries of the Region was sponsored and the Regional Office was represented in the Workshop on Low Cost Housing, organized by the United Nations and the Economic Commission for Africa in Tunis in October 1961 and in the Workshop on Urbanization Problems in Africa, held in May 1962 in Addis Ababa.

#### MEDICAL REHABILITATION AND PHYSIOTHERAPY

225. Planning of medical rehabilitation facilities should follow the priorities established in the General Health Plan. Assistance in medical rehabilitation projects in a country will become increasingly important as a good coverage by general health and medical care services has been established throughout that country. On the recommendation of WHO consultants, assistance to medical rehabilitation projects is being planned in Iran and Tunisia.

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\* Off.Rec.ECOSOC, 32nd Session, Supplement No.12 (E/3489), Chapter IV

226. Close association continues with the United Nations Bureau of Social Affairs which is responsible for the social and vocational aspects of rehabilitation, and with UNICEF which provides supplies especially for projects serving physically handicapped children.

227. Previously WHO-assisted activities in Israel and Lebanon continue while further WHO assistance in Lebanon is being planned. A prosthetics technician has assisted Pakistan in establishing the Prosthetics Shop in Karachi on a firm basis and further assistance will be provided in 1963 and 1964. Training of physiotherapists is carried out with WHO assistance in Iran and Pakistan.

#### MENTAL HEALTH

228. In view of the advent of social and economic developments and the subsequent cultural changes coming in their wake, the programme for mental health\* had to be planned on a short-term basis and in a manner allowing for flexibility and for any modifications made necessary by the trend of emerging experience. In such a fluid state, where the structure of mental health rapidly passes from one phase to another, the order of priority may sometimes become a matter of controversy. The emphasis of the worker in the field and the standpoint of the planner in the office may sharply contradict one another. The deciding factor in priority may indeed become psychological rather than logical and idealistic rather than realistic, and what begins as psychological may end as an urge and loom as a dire need. Moreover, participation of civic and lay public bodies has greatly influenced the trend of health services. It has brought the weight of demotic factors to bear at all levels of planning and as a result the order of priority and the structure of health assistance itself have become deeply affected. In such a mood it is difficult to insist on any technical order which is not fully shared by Governments. Furthermore, and this is perfectly true, the rising level of aspiration in the public and its growing influence in health and civic matters have led to programmes which may not be adequate from the

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\* See: Annex III

wider view point. But surely health is not entirely a medical concept and the role of the social, economic and other factors is no less important, especially at this evolutionary stage in the Region, characterized by great events of social character. Indeed, the contribution of civic and voluntary bodies in certain aspects of health planning and assistance is not yet fully appreciated and exploited, despite the fact that they are in a position to make a very useful contribution, especially in relation to the anthropological dimension and territorial needs. It is therefore highly important that the participation of civic and especially of voluntary bodies should be invited, whenever such participation is enlightened and informed.

229. Moreover, in view of the rapid pace of social and economic change in the Region, health planning has not perhaps been able to keep abreast of the evolutionary needs of the rapidly developing communities it serves. This is perhaps the case among most developing countries. And as a result some involutory and devolutionary problems of health have become manifest in the services. To remedy this type of specific deceleration, there is need for a global approach. Indeed, the promotion of health services from one level to another should be taken in the total view rather than in the phenomenological view which typically deals with services in terms of singular categories fitting in a mosaic pattern. The training of staff by itself, for example, would not solve such incapacity without equally sponsoring the promotion of the curative, the domestic, the rehabilitational and the preventive as well as the administrative measures involved. Equally important, and this should be even more stressed, is the reorientation needed in the human approach, parallel to the new situation, so as to foster a new level of patient-doctor-community relationship appropriate to the new developments in the community. Surely the impact of new measures of treatment and the improvement in the quality of living in institutions triggers new needs and creates new forms of self-expression. Perhaps the capacity of the physician to change his own attitude in the field of human relationships in general and in the patient-doctor relationship in particular is the most difficult to achieve.

230. Nevertheless, experience has shown that during the last few years two events impelled by socialistic trends have managed to bring into focus the importance of the community in health, as a result of which the role of the physician, patient and the community have shown remarkable change in emphasis. This demonstrates the important fact that medicine follows in the footsteps of the community and in consequence the indications of each stage of progress in medicine are signalled by the society in its rate of progress and in the trend of such progress. It further demonstrates that in order to obtain a better standard of medicine it is necessary to promote the community. Finally, it implies that the health expert cannot afford to remain in isolation from the society and its culture for long.

231. Following the First World War and perhaps even more so the Second, medicine had reached a crucial phase, where its future potentialities could no longer be developed within the limits of its own premises. This pre-occupation became all the more real with the impact of the developing social science techniques. It became instrumental in firing the signal and medicine burst out into the social field. Its identity with the community and with the social, economic and cultural patterns became finally established. Thus the Gordian knot was broken.

232. In the second instance, intensive industrial and agricultural developments, by accelerating the polarization of social groups, roused and impelled an acute sense of self-discovery and self-awareness, which were factors of great importance in health politics and consequently in the formulation of health planning. These among other things, were clearly the early heralds and manifestations of the newly emerging social class in the Region. Cotton growing on a commercial scale in one country of the Region has brought about some novel features in health, amongst which is the stability it confers on the high grade mental defective who is more suited to the monotonous job of cotton picking than the normal, and who consequently tends to earn relatively more.

233. The differing levels of evolutionary development as well as the differing tempo of health services in the various countries of the Region have made it possible for public health personnel in this Office to discover, identify and trace appropriately the evolutionary quality of health in both the phenomenological cross-section of its present-day status as well as in the longitudinal section of historical times. With this came the realization that health is in essence a quality of a community in action; in other words it has no quality of its own. The nature of health is in fact adjectival to the nature of the community. In view of this it can be said that the status of health is not clearly separable or distinct from the status of the community, nor from the historical and social order of its setting, because health is people and there can be no definition of health outside people and without reference to their standards of cultural and social achievements. Thus health is a function of levels of social stratification and social attainment, using the word "social" in the widest possible connotation.

234. Following is an abridged outline of the proposed three-year programme.\* This Region is passing through a phase of intensive development and the shortage of trained personnel constitutes the most serious problem. Moreover, the public demand for better health services is increasing as a result of public awareness and its growing influence in the management of its affairs. This may set up a vicious spiral.

235. Training of Psychiatrists. The training of psychiatrists abroad and within the Region is progressing. But the momentum at present is slow and does not squarely meet the intensity or the urgency of the need. In some countries of the Region, the programme of post-graduate training has not yet been revised and brought up to contemporary standards but has remained unchanged, thus the training has not kept pace with the new events in the social and economic order; nor has as yet the ecological concept of mental health sufficiently penetrated into the curricula in some countries, and the concept of medicine as taught and as applied still remains scientific and

\* See: Annex III

technological in definition, no more and no less, and without reference to its social character. Notwithstanding this, we feel optimistic that the realization is growing regarding the importance of the socio-economic and cultural factors and that positive efforts are being concentrated in the direction of using such criteria for the interpretation of health assistance and planning.

236. This Office is endeavouring to expand its budget to enable more and more psychiatrists to have training. Some candidates, on fellowships, spend three months at the Lebanon Hospital for Nervous and Mental Disorders to familiarize themselves with the ecological implications of the problem in the Region and the broader aspect of psychiatry in the West and North America. This system could provide an assessment of candidates and of their suitability for their higher studies. In fact, an assessment of the first two candidates was confirmed by the favourable progress of their studies and the successful result of their final examination for the DPM at the Institute of Psychiatry in London.

237. In this respect, it is felt that more working links might be established with Regional hospitals with adequate facilities and competent staffing, for the purpose not only of training but also of research, as the nature of some Regional problems in mental health may not be amenable for research outside the cultural and environmental context.

238. It is necessary to stress here the importance of clinical progress and discoveries and the influence of clinical trends in general on administration and planning. The far-reaching effects of some newly discovered drugs on the administrative patterns in general and hospitalization in particular have made it indispensable for planners and administrators to follow keenly the developments in the clinical field as part of their task. Indeed the same applies to physicians. New drugs have broken the barrier between the curative and the preventive for the first time, as in the case of antibiotics in yaws and syphilis. Drugs have made it possible for hospitalized

tuberculous patients to be treated extra-murally under domiciliary conditions, thus reducing the cost of treatment tremendously. Indeed, effective drugs may come at very short notice and a situation may arise demanding a sudden complete orientation of policy. In this respect it should be mentioned that this Office is actively participating in post-graduate medical training, and a member of the staff is regularly engaged in lecturing to a post-graduate class in Alexandria University. In this way the Office is not only contributing but is also systematically following the progress in the clinical field.

239. Training of Nurses. Fellowships for higher training of nurses abroad are still granted to suitable candidates and will continue to be granted whenever circumstances make it possible.

240. In view, however, of the emergency conditions in the Region, the need for intensive short-term training as a stop-gap is keenly felt, and a WHO-assisted Regional programme was thus started at the Lebanon Hospital for Nervous and Mental Disorders in January 1962 for the first group of twelve Regional nurses. It was initially decided that a six months' intensive training might qualify candidates for work in some hospitals, especially as in-service tutors - a category of personnel which is urgently needed. An additional month, making a total of seven months, was subsequently added for instruction in social techniques to fit the nurses for better community work. At the present evolutionary stage of some countries, social work would certainly be more profitable if integrated as part and parcel of the nursing task. Differentiation at the present level may not serve its purpose. It needs no apology to say that it is felt that the level of nursing should go hand in hand with the level of community development and the standard of medical work in general. The ecological concept of social work has penetrated the design of social techniques.

241. Mental Health Services for Children. In 1964, the organization of mental health services for children within the framework of paediatric services will be discussed by a small group of experts. It is thought that

this could perhaps be carried out in Kuwait, in view of some considerations which are extremely favourable to such a study.

242. Little has so far been done in the Region for children in this respect. It is felt that the provision of health services has so far been concentrating on adults. This Office feels that children's services have a very important preventive aspect longitudinally and that such services should be organized on the clear understanding of what constitutes the concept of child health, because the child is not a miniature adult and therefore adult services cannot provide adequately for his needs.

243. The nursery in Kyrenia, Cyprus, which is run on economic lines for working mothers (five shillings a week) illustrates that many of the working-class children who joined the nursery with potential neurosis, such as bed-wetting, recovered very quickly. Moreover, we feel that this is the only possible way of raising the standard of living of working-class children whose parents' income cannot possibly be raised for therapeutic considerations, as they stay most of their waking hours in the nursery where the standard of living and the conditions for the development and promotion of health are very much higher than in their homes, thus safeguarding in turn the mental health of the mother. It is a great tribute to the municipal authorities of Kyrenia that such important work has been established for the community.

244. The Problem of Chronic Patients. The maintenance of chronic patients in hospitals is a serious cause for depletion of funds and overcrowding of hospital beds. By occupying beds for long periods the chronic patient seriously prejudices the admission of the early recoverable case, thus contributing to chronicity by a vicious spiral. As a legacy of the past, there are large numbers of chronic patients in most Regional hospitals and in view of the importance of this state of affairs, a small group of specialists is scheduled to convene perhaps in Teheran to discuss the subject in the near future. Important papers on the management and rehabilitation of chronics

have been provided by invitation. At the Lebanon Hospital for Nervous and Mental Disorders a special unit for chronics, run by a competent nurse who gained his experience abroad on a WHO fellowship, with a specially trained staff, has been working for some time with excellent results.

245. Clinical Psychology. In view of certain historical factors of an evolutionary nature, it is felt that the best contribution by this Office to the promotion of clinical psychology is to encourage the educational authorities to develop departments of psychology, to enable psychologists to concentrate on their specific task for the adaptation and standardization of tests and the construction of new ones if necessary in relation to the specific demands. Though such efforts are being made, the number of psychologists actually engaged in educational work is rather small. As a second step, psychologists for clinical medical work are to be drawn largely from these centres. This fact is important when the special circumstances of clinical psychology in the Region are considered. It is important to emphasize strongly that the task of the clinical psychologist lies in his specific field as a member of the diagnostic-therapeutic team. The present conditions, where some of them are independently practising as therapists, would not be sustained for long, especially with the growing critical tendencies of the public and the tightening of the medico-legal responsibilities of practitioners. Nor would such a practice be conducive to the welfare of psychology itself, especially in the case of psychometrics (intelligence and personality tests) which constitute the most essential part of their work.

246. It must be said that this state of affairs is not peculiar to this Region in any way. It has happened before in the West and in North America and should be regarded as part and parcel of the evolutionary development of psychology in relation to medicine everywhere. It is an inescapable phase in the developmental history of any service.

247. Social Work. By the ecological concept of social work we mean the organization of social techniques and enquiry for the assessment of the

specific social needs in relation to the resources available, real and potential, for the rehabilitation of the beneficiary in the light of his needs as determined by the circumstances of his environment, social, economic and cultural. The definition also covers the selection of ways and means of delivering such relief drawn from the available resources in a way that encourages the revival of self-confidence and the regaining of self-esteem with the stimulation of the initiative and the sentiment for self-dependency when the circumstances change.

248. In the historical light such institutions have long existed in one charitable form or another in this Region and have acquired a certain connotation of their own which may not be moralising, or encouraging for the needy utilize them. It is important to mention in this respect that the great danger to the objectives in social relief is to allow the beneficiary to develop a dependency reaction which is commonly fostered by charity. This should be rigorously avoided. On the contrary, one should foster in the recipient a sense of self-confidence and a desire for independence when the circumstances alter. Nor should the recipient be allowed to indulge in feelings expressive of inferiority or unworthiness as social relief is a right and not a grace in any civilized community. As the Region is pioneering the administration of social work, popular education should concentrate its media on the subject, and the idea of charity as synonymous with such work should be eliminated. The social worker who behaves as though he were the donor would find himself in the most difficult situation. It is encouraging, however, that the pilot projects in this sphere have proved that the attitude of communities which may appear rigid and irreversible can easily be reversed if confidence is gained.

249. An assignment of an expert in social techniques is under consideration and it is hoped that he will participate in the programmic design of all health projects.

250. Epidemiological Studies. It is planned that perhaps late in 1963 or early 1964 epidemiological methods and techniques will be the topic of a demonstrative study for Regional mental health and public health experts for the purpose of exchange of information on a basis of understanding. But notwithstanding this, the Office is aware of the implications of such studies, especially in a subject like psychiatry, where the categories are still defined on school systems, and general consensus does not by any means exist.

251. The application of epidemiology in the field of mental health has been the subject of a paper issued by this Office\* which stresses some practical aspects peculiar to the culture which should be considered when organizing any epidemiological programmes.

252. Research. The feeling is growing that research cannot be divorced from the daily activity of the clinician and his routine, nor is it possible to separate teaching from other activities, as the function of the clinician still continues to be three-fold, as described initially by Hippocrates himself: therapy, teaching and research.

253. Perhaps it may be necessary to define in some terms what is meant by research in the Regional sense at the present level of organization of service, which sets a limit to the level, trend and nature of any research. From the outset, one should admit that in the present prevailing conditions of shortage of staff, equipment and funds in many countries of the Region, it would not be possible, or even appropriate, to establish any form of highly academic research of no immediate utility. Nevertheless, there are other fields of research no less important in relation to the concrete and immediate needs of the services. It must be made clear that the primary task of the health expert in the present circumstances of the Region is the provision of services to the sick and the maintenance and promotion of the health of the community. At the present stage, the mental health expert in particular

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\* EM/MENT/29/3

may find himself in a pioneer situation where efforts may determine the future organization and development of these services. For this reason, the training of psychiatrists at this stage should be thorough, competent and highly organized, to enable them to cope with situations where they may have to work independently of any other help in the country. Moreover, and this is essential, the initial task in pioneering work should begin by the development of techniques first, rather than practices. In such circumstances, few can afford indeed to go into any type of research outside the context of what is meaningful to the immediate task of the moment. In his daily contact with his patients, their families and the community, the clinician may be able to discover some extremely important leads which he may be able to use for research. If these leads are properly followed and investigated, significant results may ensue. There are also the "Experiments of Nature", to which special emphasis should be given. In the course of the rapid pace of socio-economic development and the cultural changes associated with it, many situations of challenge and of contrast have evolved and the physician as a community worker may find himself face to face in his routine with many novel and challenging situations of extreme interest and provocation. The acute observer may find before him an open field most appropriate to his needs which he may be able to investigate as part of his daily routine. Nature has provided for him topics of research, design of the procedure and even the plans of work.

254. To illustrate one of these experiments of nature due to the sudden impact of novel socio-economic factors, a case should be mentioned in which it was possible to separate roughly the biological order in an important type of sex deviation. In another experiment of nature, due to sudden accession of some economic factors, an anomalous picture of neurotic disorder became rife in women, which on analysis enabled investigators to have a better insight into the dynamics of neurosis and interactions of health in relation to social change. Further light was shed by this experiment on other types of disorder which had been quite dubious until then.

255. The present circumstances of the Region provide one of the most exceptional opportunities for the study of these experiments of nature, because the social and economic aspect of change has given nature an opportunity to experiment in isolates of variable combinations. Moreover, the differences of social, economic and cultural nature in the Region provide an opportunity not only for studies of static phenomena but also for the study of such phenomena in the course of their phasic changing. The comparative results of such studies involving different combinations of cultures or sub-cultures may be extremely instructive. Indeed, it is due to the inspiration provided by the situation in the Region that this Office has been able to expound the conception of health, especially in the evolutionary sense.

256. Mental Health of University Students and the Intelligentsia. This Office is studying a plan for the promotion of the mental health of university students and the intelligentsia and is in the process of analyzing the subject in terms of the different disciplinary aspects involved. As an emerging class the intelligentsia in the Region have their peculiar problems, which is understandable. At the moment this subject is being studied from the historical, educational and social aspect as well as from the wider cultural view. It is important to say that the influence of this militant class, which is agitating for a status, has far reaching effects, not only on the stability of the modes of adaptation of its members but also on their nations as a whole in widely differing spheres.

257. From the example of one country in the Region where the intelligentsia class has already fused and smoothly integrated itself into the community at large, it might appear that certain geographical and historical factors as well as experiential factors are important in this respect.

258. In the case of the university student, special health services are beginning to develop; these services may give one of the best illustrations of how an educational process and the social are combined. For this reason such services would have a dual advantage in contributing to our understanding of some factors of aetiological importance in the health of young groups.

NUTRITION

259. There have been encouraging developments in the field of nutrition during the year. Two countries (Jordan and Lebanon) are completing nutrition surveys with bilateral assistance, the results of which are expected to form the basis for the development of their national nutrition programmes. Surveys are planned or are at the pilot stage in Iran, Pakistan and the United Arab Republic. In the first mentioned country, a Food and Nutrition Institute has been established in the Ministry of Health. The training of nutrition officers has been undertaken in these countries. Teaching and research in applied nutrition are planned in other countries (Ethiopia, Sudan).

260. In Somalia, rehabilitation measures were taken for the relief of food shortage caused by drought and subsequent heavy rains and floods. As a result a Food and Nutrition Committee has been established, which in the future will assist the Government in organizing a long-term nutrition programme.

261. In Libya and Tunisia, strengthening of nutrition education programmes is planned through improved cooperation between the Government and WHO-assisted public health and maternal and child health services. The information on nutritional diseases, local food and feeding habits obtained through maternal and child health training centres and by surveys will be incorporated in the health and nutrition education programmes. In Saudi Arabia, the Syrian Arab Republic and Yemen, nutritional data are being collected on a local scale in health training centres and are used for nutrition education of mothers on a local basis.

262. The Public Health Nutrition Programme. It is expected that the increasing activities of Member States will result in a proper application of the available nutritional knowledge in the public health programme. In

the last two decades the study of applied nutrition has contributed to breaking down the approach based on scientific methods only. The importance of human factors, social, cultural and economic aspects has been recognized and field studies have shown that nutrition is a community problem, requiring a public health approach. The widespread malnutrition especially of mothers and pre-school children cannot be solved by therapy, or by supplementary feeding programmes alone, and these should not be over-emphasized to the extent that preventive programmes become impossible because of a limited budget. It should be kept in mind that it is far more economical and satisfactory to prevent nutritional diseases through organized community effort than to try to effect a cure of even a small number of them. Public health nutrition apart from preventing disease promotes health.

263. Organization of the Public Health Nutrition Programme. In each country there must be a nucleus around which the programme can be built. Some countries in the Region already have some kind of structure for a nutrition service on the national level in their Ministry of Health. Without this no success may be expected and much effort to improve food and nutrition is spoilt because of lack of coordination, overlapping and contradictory policies.

264. The relatively small budget needed to create a central section for nutrition is fully justified because through its guidance and coordination and without additional cost, appropriate investigations and remedial activities can be incorporated into the routine duties of health personnel and also of teachers and other workers at the local level.

265. In some countries a beginning should be made with a small nutrition unit attached to the Division of the Maternal and Child Health Service or of the local health services in the Ministry. If the budget and the personnel are limited, the maternal and child health officer may act as part-time public health nutritionist to stimulate and coordinate all possible efforts to improve nutrition. He should form a small team with a public health nurse and a home

economist who in the beginning may also be part-time and be made available by other departments. After having gained practical field experience at home over a period of years the members of the team may obtain additional training abroad or benefit from association with international experts in nutrition assigned to the country. If for the time being no national personnel is available, the assistance of international personnel should be requested to establish a central nutrition unit. At the next stage the small nutrition unit may grow into a separate section, but still be closely associated with other departments in the Ministry of Health.

266. The third stage often involves the setting up of a nutrition institute which has a certain autonomy from the administrative and technical point of view, but has to cooperate closely with other public health departments, particularly maternal and child health, rural health services, medical services and health education.

267. In several countries a nutrition committee or board has been established composed of members with duties in various departments. These committees are very useful to coordinate nutrition activities in the Ministries of Health, Agriculture and Education but they usually act in an advisory capacity only and have no executive power. One of the first things for the committee to do is to create a nutrition unit in the Ministry of Health as described above. The medical officer of this nutrition unit can act as the secretary of the committee.

268. It is advisable to operate a public health nutrition programme on the state level. This is more economical and provides coordination with agricultural and educational services on all levels. The applied nutrition programme would involve local contacts by local public health and other personnel rather than by the nutrition staff of the Ministry whose functions would be more advisory and consultative.

269. Functions of a Nutrition Unit in the Ministry of Health - Training.\*

The main function of the nutritionist of the Ministry of Health should be to bring the available knowledge and resources for improved nutrition to the people, particularly through all health personnel, who should do this work during and in addition to their daily routine duties. The nutritionist and his team have to train the workers who are in contact with the general population on a local basis.

270. The instruction in applied nutrition should be included in the curricula of the faculties, the schools of public health medical personnel and auxiliaries, in the curricula of school teachers colleges as well as of schools of agriculture and social welfare. It can also be given through training courses, workshops, local seminars or in-service training. The instruction should be largely confined to practical demonstrations of the role the trainee should play in implementing the nutrition programme. It is important that the nutritional practices in need of change be taught to the public. The content of the teaching should always remain the same in each area. Only in this way may the advantages of improved nutrition be realized by the population.

271. Field Research. Two main problems in this Region are malnutrition of the pre-school child and of the mother. Therefore, the nutritionist and his team have to investigate in each area, urban or rural, cheap and acceptable nutrient food for mothers, infants and pre-school children. The introduction of appropriate locally available semi-solids in the second half year of an infant's life would contribute greatly to preventing marasmus and kwashiorkor in thousands of pre-school children. The increased calorie, protein and iron intake will prevent anaemia in many mothers.

272. To sum up, it is felt that efforts during the next few years should be concentrated on: (1) The establishment or the strengthening of a central nutrition unit in the Ministry of Health; (2) The establishment of a country-wide applied nutrition programme with local adaptations concerning a few simple

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\* Joint FAO/WHO/Expert Committee in Nutrition, Second Session - WHO Technical Report Series 44, Geneva 1951

practices most urgently in need of improvement; (3) The inclusion of training, based on this nutrition programme, in all curricula (from medical faculty to village midwives). Short training courses and in-service training should be given to as many people as possible, whose work brings them in contact with the general population on a local level. The training should be given mainly by practical demonstrations pertaining to local conditions.

#### RADIATION MEDICINE

273. The programme and budget estimates for the Eastern Mediterranean Region are not indicative of the importance given in the Region to the problem of radiation protection, and the development of activities in this field. It may be considered that the preliminary period of study has now been completed and a more active phase of tangible assistance to the Governments is approaching.

274. Several countries of the Region have been visited by the Regional Adviser on Radiation and Isotopes and enquiries have been made locally on the hazards resulting from the use of radiation, especially in medicine. Advice has been given to the health authorities concerning sound programmes for preventing health hazards from radiation of any origin, with the result that several Governments have taken action such as appointing an adviser on radiation in the Ministry of Health; convening an advisory committee meeting to prepare local regulations or legislation; creating an executive bureau for applying preventive measures of protection.

275. Assistance from the Regional Office consisted essentially in granting fellowships for training doctors and technicians in radiology, in enabling public health personnel to go abroad to become acquainted with the work in radiation protection services, in sending participants to the training courses on radiation protection organized by WHO: one participant followed the course in Shiba City in Japan; six others are destined for a similar course in Dusseldorf.

276. A consultant from Headquarters passed through a country of the Region to plan a research project on human genetics; at the same time he was able to make first enquiries in an area where the radiation background is abnormally high.

277. The Regional Adviser on Radiation and Isotopes took an active part in the teaching at the training courses organized by the International Atomic Energy Agency in Cairo and Athens. In addition, at medical meetings in the countries visited, he reviewed the public health aspects of radiation hazards.

278. It is envisaged that the future programme will include: more fellowship awards for training specialists in radiation medicine, with a special allotment in the budget for the purpose; short-term consultants; the organization of a training centre for tutor technicians in X-ray; a group meeting of Regional consultants to plan a general programme in radiation protection; the organization of a training course on radiation protection for public health personnel.

### III ADMINISTRATION AND FINANCE

#### GENERAL

279. No major change has been made in the structure of the Regional Office or the organization of the Regional Advisers, but there has been a modification in the Fellowships Unit where a full time medical officer has been appointed, one administrative officer has been replaced by two administrative assistants, and close cooperation has been ensured within the section dealing with education and training, courses and fellowships.

280. An effort has been made to bring the basic WHO agreements with Governments up to date with the result that five revised agreements have been signed and two are under negotiation.

#### PERSONNEL

281. The staffing of the Regional Office has undergone some changes during the year in accordance with the revisions approved by the previous Regional Committees and the World Health Assembly. Among these are the suppression of one of the two posts for Nursing Advisers and the administrative post in the Malaria Eradication Coordination Unit. Three of the senior Public Health Administrators have been transferred, one as WHO Representative in Ethiopia, one to the Regional Office for Europe and the third to Headquarters. On the other hand two senior posts have been filled through recruitment within the Region. Also on the administrative side, there has been a marked turnover, as a senior Administrative Officer has reported for duty while arrangements have been completed for Mr. R.S.M. Sundaram's transfer to Headquarters late in July, in line with the adopted rotation policy both the Budget and Finance Officer and the Accountant have been transferred during the year and have been replaced by experienced officers from other WHO offices. Ten of the general service staff left on resignation or transfer while four were recruited and nine temporary staff members were formally employed to fill

other vacant posts. Four of the general service staff members were promoted within the Regional Office to fill posts in the professional category.

#### BUDGET AND FINANCE

282. In spite of the change in staffing referred to above, and which comprised new incumbents in three of the four professional posts, the unit has managed to cope with its tasks, including the introduction of suitable procedures to enable the Regional Director to carry out the additional authority to revise allotments issued by Headquarters for field activities without prior reference to Headquarters.

283. The further development of the Staff Health Insurance scheme covering staff members and their dependants involves a great deal of additional work and supervision as the number of claims during the period under review has been double that of the corresponding period ending 30 June 1961.

284. Another feature of importance has been the introduction by the Technical Assistance Board of project planning, and approval of the projects for their duration, up to a four-year period. This will apply to the biennium 1963/64 for which the preparatory work, followed by consultation with the Health Ministry, the coordinating authority in each country and the Resident Technical Assistance Representative, was effected in the first half of 1962, and the final requests from the individual Governments were submitted to the Technical Assistance Board in June of this year.

285. Continued attention to project and budget analyses made it possible in the latter part of 1961 to devote available savings both under Regular and Technical Assistance funds to meet priority requests from Governments, and particularly for fellowships, which had not been specifically provided for in the approved programme and budget.

286. Turning now from the period under review to the budgetary provisions for 1962 and the plans drawn up for 1963 and 1964 it will be seen from the following table and from Figure VIII (opposite page 107) that the probable

Figure VI

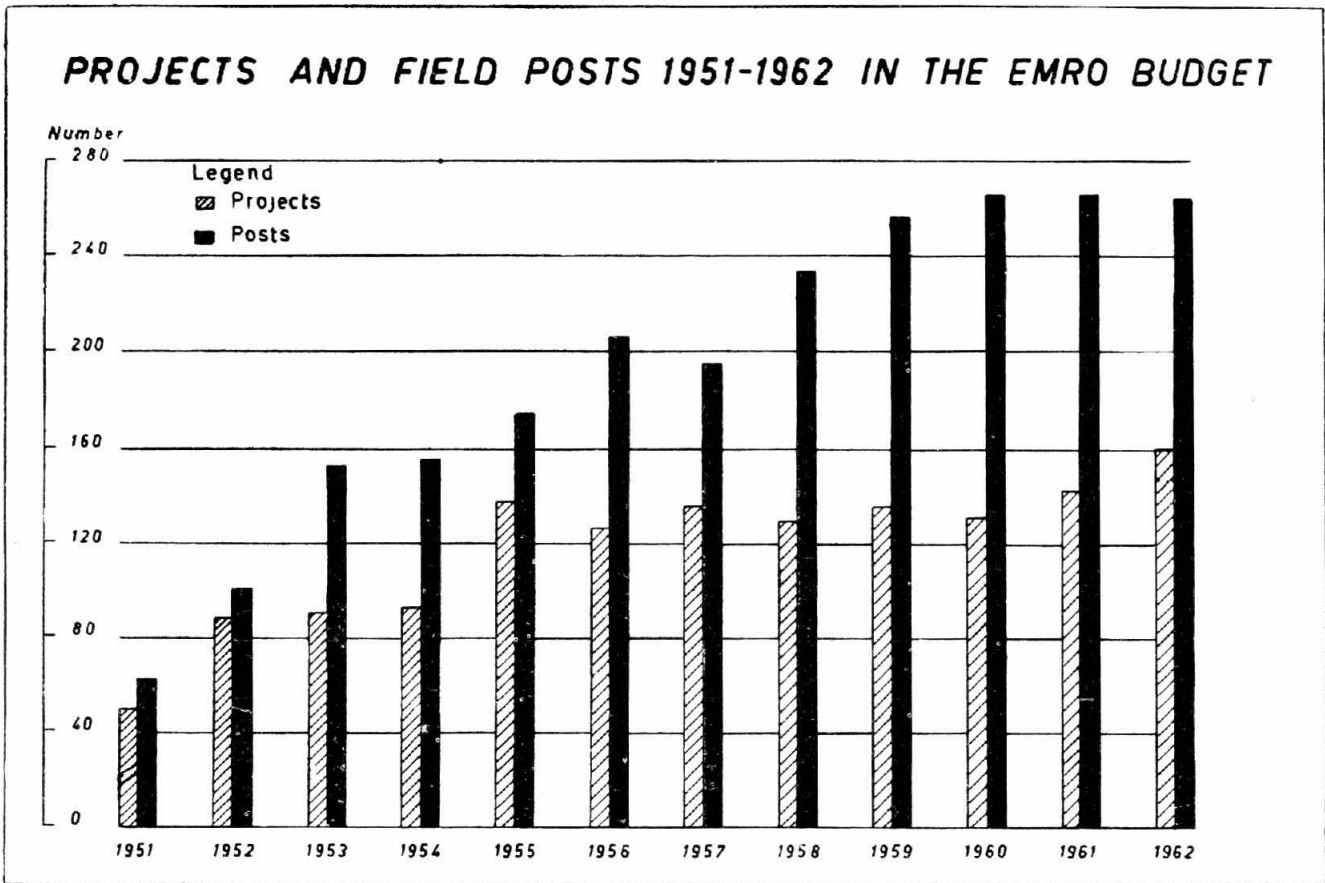


Figure VII

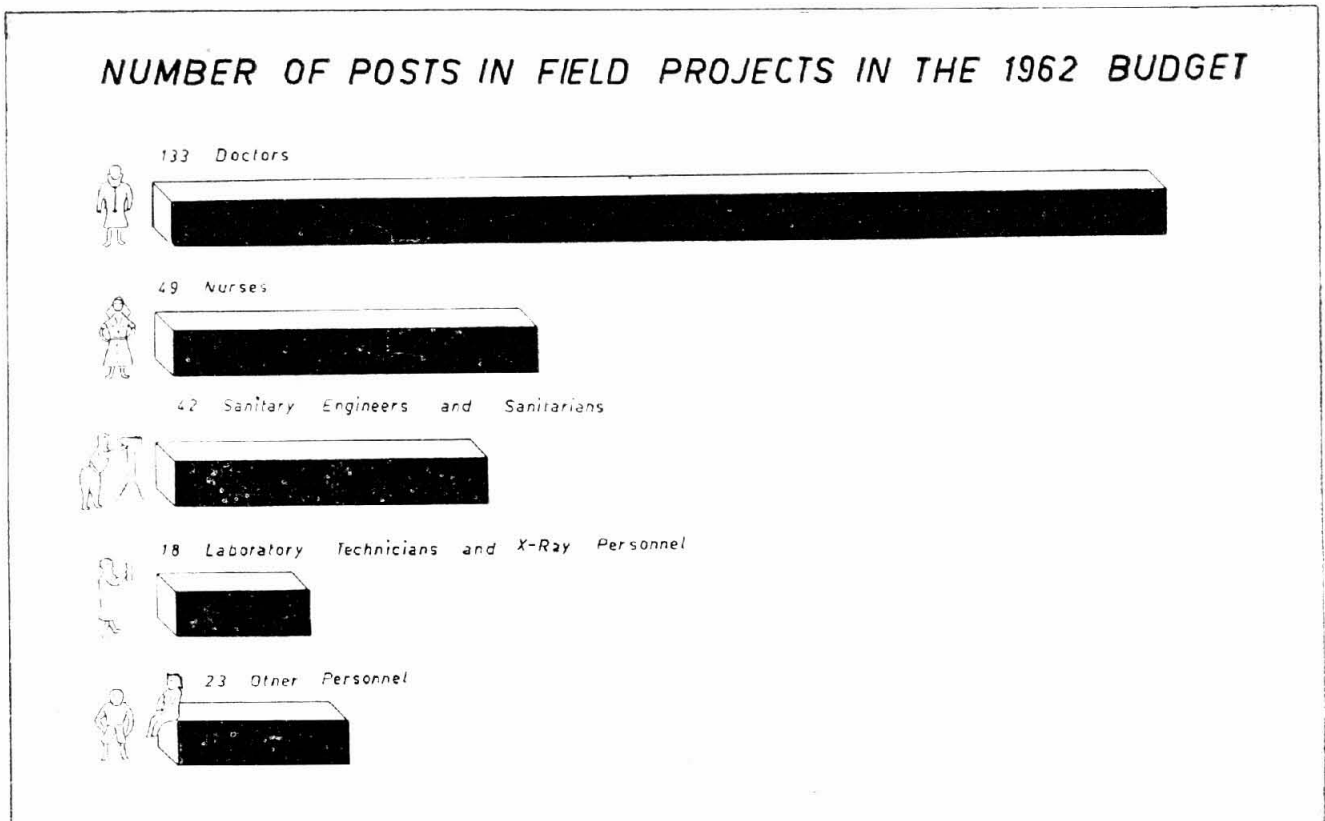


Figure VIII

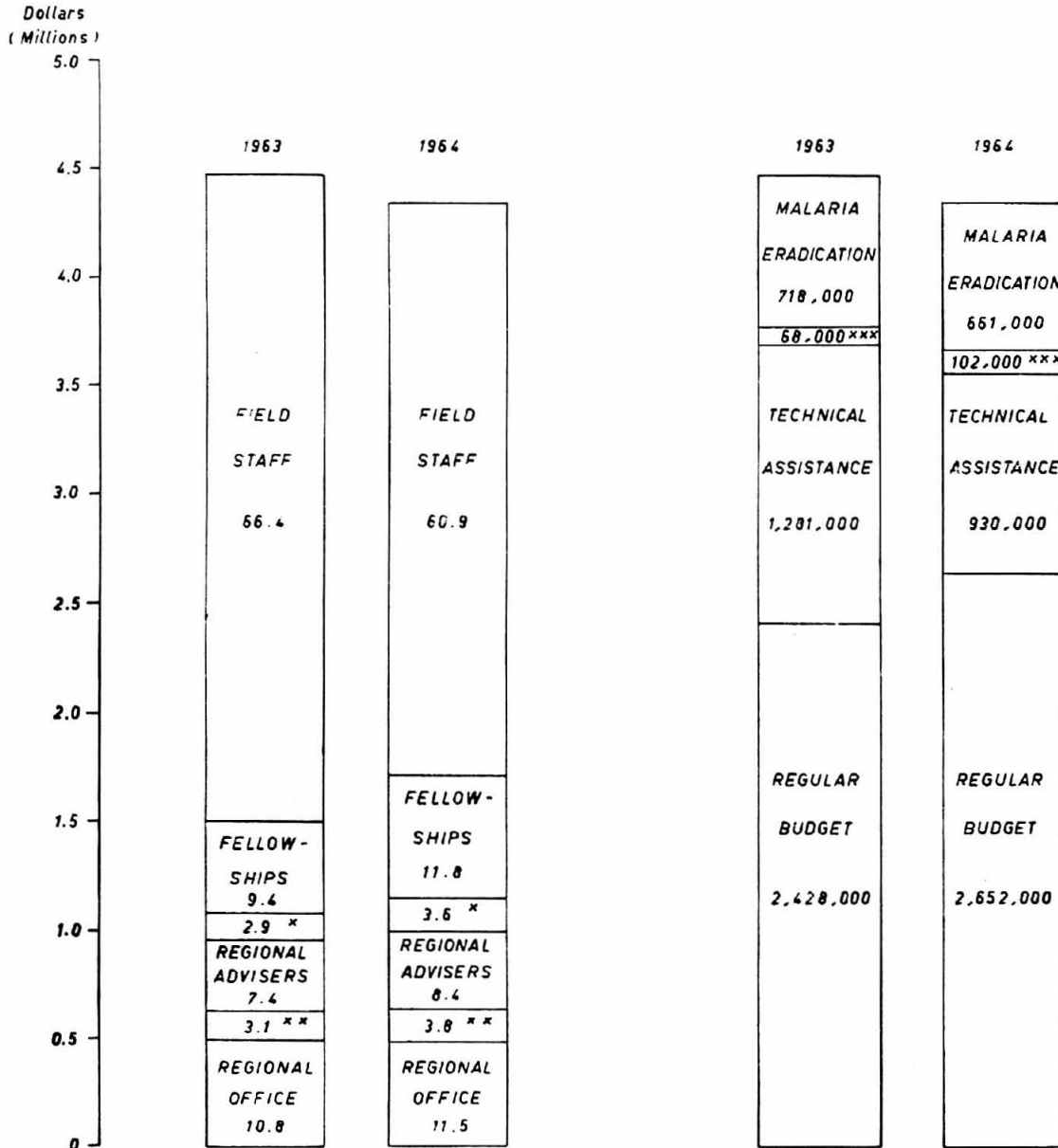
## ESTIMATED BUDGET REQUIREMENTS 1963 AND 1964

### A. DISTRIBUTION OF EXPENDITURES

FIGURES INDICATE PERCENTAGES  
OF TOTAL EXPENDITURE

### B. SOURCE OF FUNDS

FIGURES INDICATE  
US DOLLARS



x SUPPLIES AND EQUIPMENT  
 x x WHO REPRESENTATIVES  
 x x x COMMUNITY WATER SUPPLY (SPECIAL ACCOUNT)

increase in funds for 1963 from all sources will be only about three per cent higher than in 1962. While the allocation of Regular funds shows a welcome increase, this is to a great extent offset by the very modest increase in Technical Assistance funds and a reduction in the funds expected to be available from the Malaria Eradication Special Account. With regard to 1964, a slight decrease is foreseen as compared with 1963. This is mainly due to the uneven distribution of Technical Assistance funds in the two years of the biennium as presented in the final submission of the requests from Governments to the Technical Assistance Board. During the actual implementation of the proposed activities in the next biennium there is likely to be more harmony between the two years.

	<u>1962</u>	<u>1963</u>	<u>1964</u>
	\$	\$	\$
<u>Regional Office</u>			
WHO Regular	465,000	486,000	499,000
<u>Field Activities</u>			
WHO Regular	1,660,000	1,942,000	2,153,000
WHO Technical Assistance	1,220,000	1,281,000	930,000
Malaria Eradication Special Account	940,000	718,000	661,000
Special Account for Community Water Supply	75,000	68,000	102,000
	<u>4,360,000</u>	<u>4,495,000</u>	<u>4,345,000</u>

287. Figure VI reflects projects and field posts for the years 1951 - 1962 in the Regional budget; Figure VII indicates the number of posts in the 1962 budget. Figure VIII indicates the revised budgetary requirements for 1963 together with the proposed programme and budget estimates for the Eastern Mediterranean Region in 1964.

MEDICAL SUPPLIES AND EQUIPMENT

288. During the period under review, purchase authorizations for medical supplies and equipment, books, journals and periodicals covering 1,957 items amounted to \$550,361 inclusive of packing, insurance and freight. The table on page 109 shows a comparative expenditure on supplies and equipment from 1955 to 1961 inclusive.

289. Continued interest has been shown by Member Governments of the Region in "Supply Services by WHO to Member States on a reimbursable basis". Reimbursable purchases were processed in the Regional Office for Jordan, Kuwait, Lebanon, Libya, Saudi Arabia and the United Arab Republic, consisting of surgical and diagnostic equipment, X-ray machines, appliances and accessories, teaching and demonstration equipment and vaccines.

290. The Regional Medical Supply Officer was detailed to Somalia in December 1961 to help in the flood relief operations. Pending the assignment of a full-time Pharmaceutical and Medical Stores Adviser under inter-country programme EMRO 76, the Regional Medical Supply Officer has been assisting the countries in the Region in this programme.

SUPPLIES AND EQUIPMENT

Country	1955 \$	1956 \$	1957 \$	1958 \$	1959 \$	1960 \$	1961 \$
Cyprus	812	350	400	-	-	-	-
Ethiopia	22,552	19,850	36,230	27,836	25,895	12,844	3,315
Iran	49,305	3,610	35,383	15,606	16,192	2,494	2,654
Iraq	15,066	14,550	6,570	3,325	11,115	5,870	4,800
Israel	5,617	550	27,500	18,000	-	2,300	-
Jordan	19,436	2,305	13,640	12,035	7,807	11,378	16,761
Lebanon	30,956	11,830	31,900	1,980	12,800	7,770	9,057
Libya	7,543	470	2,455	9,880	4,944	4,715	2,660
Pakistan	19,630	3,840	15,445	11,134	40,582	392,624	369,089
Saudi Arabia	9,546	8,575	29,810	13,400	5,678	2,842	3,866
Somalia	4,000	50	10,500	6,200	1,804	14,000	28,053
Sudan	31,108	25,350	75,900	24,172	17,997	45,737	24,961
Syrian Arab Republic	13,900	4,100	54,854	12,690	5,094	2,573	12,401
Tunisia	2,700	1,200	42,355	17,635	35,235	4,510	7,808
United Arab Republic	34,246	21,145	79,255	39,612	30,890	19,737	15,615
Yemen	25,000	8,000	46,080	780	16,864	2,203	14,390
EMRO	20,425	9,880	14,650	6,890	24,875	79,681	38,575
Totals	<u>311,842</u>	<u>135,655</u>	<u>522,927</u>	<u>221,175</u>	<u>257,772</u>	<u>611,278</u>	<u>554,005</u>

#### IV PUBLIC INFORMATION

291. Publication of an Eastern Mediterranean special issue of World Health including an Arabic edition, increased production of features and picture stories, and extensive observance of World Health Day highlighted public information activities during the twelve months under review.

292. A fair share of publicity for WHO both in the Region and abroad originated here. Besides the widely distributed special issue of World Health on the Eastern Mediterranean Region (over 100,000 copies in six languages), features produced by the Information Unit generally reached a large audience by getting good play in several leading dailies and weeklies in the Region and outside.

293. There has been a considerable amount of interest in regional health topics, expressed on the part of international news agencies and several leading periodicals. A feature on the Mecca Pilgrimage and the WHO visiting team to the Hedjaz was reproduced by prominent papers and periodicals, including the New York Times, the Daily Telegraph, the Times, and Newsweek. Feature articles on other topics, including drug addiction, bilharziasis and irrigation, malaria eradication among nomads, and pioneering health activities also received wide coverage.

294. The preparation of the Eastern Mediterranean special edition of World Health, for which the Information Unit supplied both the text and the pictures, afforded a good opportunity to build up a master file of articles, features and write-ups giving an all-out picture of major regional health issues. This record, which will be further completed and kept up to date, will help to cope with the increasing number of requests for information material.

295. Another step to meet the growing interest aroused by WHO-assisted activities among journalistic circles, is the distribution of more press notes to single countries on subjects of specific interest to their editors and press agencies. Such press notes (26 issued during the year) usefully

complemented the press releases (41) on topics of more general interest distributed throughout the Region.

296. The past year's events which made news include the meeting of Sub-Committee A of the Regional Committee in Ohtauna, and the Inter-Regional Conference on the Training of Auxiliary Health Personnel in Khartoum.

Releases on the Regional Committee's annual proceedings aroused keen interest in the regional press but, naturally, got maximum play in Lebanese papers. Contacts with editors and press correspondents in Beirut - one of the main press centres in the Region - also resulted in the publication of more feature articles covering the main items on the Session's agenda and the dispatch of more news items by press agencies, including the Arab News Agency, Reuter and Associated Press. WHO releases and press notes ran to more than 150 columns, as against 90 columns for the previous year's meeting.

297. Excellent support was also received from the local radio which put out a 20-minute programme on the opening Session with commented recordings of the main speakers, and broadcast several interviews with representatives at the Session. Special coverage was also given by the BBC (Overseas Service), the local TV and Metro Goldwin Mayer Newsreels.

298. The Conference on the Training of Auxiliary Health Personnel in Khartoum, which focused public attention on the key functions of doctors' "right arms", also received wide coverage in the press and radio, partly because of its fully inter-regional character. The Conference proceedings were editorialized in leading Sudanese dailies and extensively commented on over the local radio which featured the opening meeting with newsreel items and recordings of the main speakers. Releases and features on the Conference topics were also well received by the professional and local press.

299. World Health Day's observances this year, possibly because of the humanitarian appeal of the blindness theme, were more widespread, better planned and more numerous. Reports from countries indicate the steadily increasing popularity of the Day, which furthermore afforded a well-timed

opportunity to draw public attention to one of this Region's major health problems. Requests for information material on eye disease control and the prevention of blindness reached this Office right up to the even of the Day. While most of the Governments published booklets, folders and posters on blindness prevention, this Office issued some 3,000 information kits, approached leading press columnists and science editors, and released number of papers on WHO-sponsored achievements in this field. Altogether 42 dailies illustrated weeklies were given special write-ups and pictures, 12 radio stations were supplied with recorded interviews and radio scripts, 4 television networks received copies of WHO-released films on eye disease prevention, and an exhibit consisting of sixty mounted pictures was set up in the WHO premises, Alexandria.

300. During the year under review, nearly all radio stations in the Region have broadcast WHO recordings produced either by this Office or by the Headquarters' radio section. Interviews with WHO regional advisers, field experts or government representatives were carried by a number of radio outlets including the UN Radio which eagerly uses such material, especially in its Arabic shortwave programme beamed to the Middle East.

301. The Information Unit further built up its photo files by assigning professional photographers to WHO-assisted field projects. Some fifteen more stories were made available, on subjects including malaria eradication (Pakistan, Somalia), tuberculosis control (Pakistan, Lebanon), bilharziasis control (United Arab Republic), midwifery (Syrian Arab Republic), medical and auxiliary education (Israel, United Arab Republic, Yemen) and mental health (Kuwait).

302. Over 70 photo stories and 850 pictures supplied by the Information Unit appeared in the regional illustrated press during the year under review - compared with 55 and 540 during the previous year. The increasing amount of work entailed by the continual growth of interest on the part of periodicals pays dividends according to press clippings compiled during the year. It is

of course the job of this Unit to stimulate such interest and to cater to it - and this in turn increases the number of requests for pictures and other information material.

303. Another rewarding development during the past year was the establishment of closer contacts with information media in several distant countries, through WHO Representatives assigned there. The method of approach to the somewhat scattered press of this Region was considerably improved with their cooperation and the distribution of information material was speeded up through the newly established pouch systems.

304. Although it is not possible to gauge to what extent the joint activities of WHO and its Regional Member States are known in this Region, press clippings compiled, reports from radio stations and requests from interested journalistic circles certainly give evidence of the steadily growing interest aroused, through the years, by WHO-sponsored activities. No doubt the health work itself, especially the all-out mass campaigns, had more impact on public opinion than the written or spoken word, but it appears from the material compiled that the production of this Unit, which was considerably strengthened during the past few years, accounts for a fair share of the publicity credit.

A N N E X E S

ANNEX I

UNITED NATIONS DEVELOPMENT DECADE

I RESOLUTION ADOPTED BY THE GENERAL ASSEMBLY<sup>1</sup>

1710 (XVI). United Nations Development Decade (I):  
a programme for international economic co-operation

The General Assembly,

Bearing in mind the solemn undertaking embodied in the Charter of the United Nations to promote social progress and better standards of life in larger freedom and to employ international machinery for the advancement of the economic and social development of all peoples,

Considering that the economic and social development of the economically less developed countries is not only of primary importance to those countries but is also basic to the attainment of international peace and security and to a faster and mutually beneficial increase in world prosperity,

Recognizing that during the decade of the nineteen-fifties considerable efforts to advance economic progress in the less developed countries were made by both the newly developing and the more developed countries,

Noting, however, that in spite of the efforts made in recent years the gap in per caput incomes between the economically developed and the less developed countries has increased and the rate of economic and social progress in the developing countries is still far from adequate,

Recalling its resolutions 1421 (XIV) of 5 December 1959, 1514 (XV) of 14 December 1960, 1515 (XV), 1516 (XV), 1519 (XV) and 1526 (XV) of 15 December 1960,

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<sup>1</sup>on the report of the Second Committee (A/5056 and Corr.1)

Convinced of the need for concerted action to demonstrate the determination of Member States to give added impetus to international economic co-operation in the current decade, through the United Nations system and on a bilateral or multilateral basis,

1. Designates the current decade as the "United Nations Development Decade", in which Member States and their peoples will intensify their efforts to mobilize and to sustain support for the measures required on the part of both developed and developing countries to accelerate progress towards self-sustaining growth of the economy of the individual nations and their social advancement so as to attain in each under-developed country a substantial increase in the rate of growth, with each country setting its own target, taking as the objective a minimum annual rate of growth of aggregate national income of five per cent at the end of the Decade.

2. Calls upon States Members of the United Nations or members of the specialized agencies:

(a) to pursue policies designed to enable the less developed countries and those dependent on the export of a small range of primary commodities to sell more of their products at stable and remunerative prices in expanding markets, and thus to finance increasingly their own economic development from their earnings of foreign exchange and domestic savings;

(b) to pursue policies designed to ensure to the developing countries an equitable share of earnings from the extraction and marketing of their natural resources by foreign capital, in accordance with the generally accepted reasonable earnings on invested capital;

(c) to pursue policies that will lead to an increase in the flow of development resources, public and private, to developing countries on mutually acceptable terms;

(d) to adopt measures which will stimulate the flow of private investment capital for the economic development of the developing countries, on terms that are satisfactory both to the capital-exporting countries and the capital-importing countries.

3. Requests the Secretary-General to communicate to the governments of Member States any documentation useful for the study and application of the present resolution and to invite them to make proposals, if possible, concerning the contents of a United Nations programme for the Decade and the application of such measures in their respective plans.

4. Requests the Secretary-General, taking account of the views of governments and in consultation, as appropriate, with the heads of international agencies with responsibilities in the financial, economic and social fields, the Managing Director of the Special Fund, the Executive Chairman of the Technical Assistance Board, and the regional economic commissions, to develop proposals for the intensification of action in the fields of economic and social development by the United Nations system of organizations, with particular reference, inter alia, to the following approaches and measures designed to further the objectives of paragraph 1 above:

(a) the achievement and acceleration of sound self-sustaining economic development in the less developed countries through industrialization, diversification and the development of a highly productive agricultural sector;

(b) measures for assisting the developing countries, at their request, to establish well-conceived and integrated country plans - including, where appropriate, land reform - which will serve to mobilize internal resources and to utilize resources offered by foreign sources on both a bilateral and a multilateral basis for progress towards self-sustained growth;

- (c) measures to improve the use of international institutions and instrumentalities for furthering economic and social development;
- (d) measures to accelerate the elimination of illiteracy, hunger and disease, which seriously affect the productivity of the people of the less developed countries;
- (e) the need to adopt new measures, and to improve existing measures, for further promoting education in general and vocational and technical training in the developing countries with the co-operation, where appropriate, of the specialized agencies and States which can provide assistance in these fields, and for training competent national personnel in the fields of public administration, education, engineering, health and agronomy;
- (f) the intensification of research and demonstration as well as other efforts to exploit scientific and technological potentialities of high promise for accelerating economic and social development;
- (g) ways and means of finding and furthering effective solutions in the field of trade in manufactures as well as in primary commodities, bearing in mind, in particular, the need to increase the foreign exchange earnings of the under-developed countries;
- (h) the need to review facilities for the collection, collation, analysis and dissemination of statistical and other information required for charting economic and social development and for providing constant measurement of progress towards the objectives of the Decade;
- (i) the utilization of resources released by disarmament for the purpose of economic and social development, in particular of the under-developed countries;
- (j) the ways in which the United Nations can stimulate and support realization of the objectives of the Decade through the combined

efforts of national and international institutions, both public and private.

5. Further requests the Secretary-General to consult Member States, at their request, on the application of such measures in their respective development plans.
6. Invites the Economic and Social Council to accelerate its examination of, and decision on, principles of international economic co-operation directed towards the improvement of world economic relations and the stimulation of international co-operation.
7. Requests the Secretary-General to present his proposals for such a programme to the Economic and Social Council at its thirty-fourth session for its consideration and appropriate action.
8. Invites the Economic and Social Council to transmit the Secretary-General's recommendations, together with its views and its report on actions undertaken thereon, to States Members of the United Nations or members of the specialized agencies and to the General Assembly at its seventeenth session.

1081th plenary meeting,  
19 December 1961.

II RESOLUTION ADOPTED BY THE FIFTEENTH WORLD HEALTH ASSEMBLY<sup>1</sup>

Decisions of the United Nations. Specialized Agencies  
and the International Atomic Energy Agency affecting  
WHO's activities: United Nations Development Decade

The Fifteenth World Health Assembly,

Considering the resolution of the General Assembly of the United Nations, A/1710 (XVI), which designated the current decade as the United Nations Development Decade in which Member States would intensify their

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<sup>1</sup>WHA 15.57

efforts to accelerate progress and the growth of the economic and the social advancement;

Cognizant of the profound effect health standards of families, communities and nations have on their social advancement and economic progress, particularly in the developing areas of the world;

Aware of the benefits accruing to health from the accelerated national programmes for general socio-economic development;

Having studied the report of the Director-General<sup>1</sup> and, in particular, the health programme for the Development Decade he has forwarded to the Secretary-General of the United Nations at the request of the latter;

Taking into account the views expressed by the Executive Board at its twenty-ninth session,

1. EXPRESSES its appreciation to the General Assembly of the United Nations for its decision to establish the Development Decade with a view to, inter alia, "accelerating the elimination of illiteracy, hunger and disease, which seriously affect the productivity of the people of the less developed countries";

2. ENDORSES the Executive Board's recommendation<sup>2</sup> that, in so far as the health aspects of accelerated economic and social development are concerned, governments participate in these programmes, with the assistance of the World Health Organization, if they so wish, by undertaking a ten-year public health programme with the objectives to raise the standards of the health of the peoples, such as:

(1) the preparation of national plans for the development of public health programmes for the Decade, co-ordinating these programmes with other related plans in the social and economic fields;

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<sup>1</sup>Documents A15/P&B/13 and Add.2

<sup>2</sup>EB29.R44, 25 January 1962

- (2) to concentrate on the education and training of professional and auxiliary staff for strengthening their health services, with specific measurable targets for expanding each category of staff, depending on pre-determined needs for each;
  - (3) to establish as baselines certain indices of their current health situation wherefrom to gauge the degree of realization of certain goals, pre-determined as target figures for the Decade;
  - (4) to devote increased national resources to the control of disease and the improvement of health,
3. CALLS attention of Member States to the proposals made and the quantitative targets set by the Director-General for a health programme for the Development Decade, as outlined in his report, amplifying the above-listed health objectives;
  4. CONSIDERS that, in developing countries, the creation of a network of minimum basic health services must be regarded as an essential pre-investment operation, without which agricultural and industrial development would be hazardous, slow and uneconomic,
  5. REQUESTS the Director-General to circulate his report to Member States, together with this resolution;
  6. RECOMMENDS that Member States study the proposals and targets outlined in the Director-General's report and adopt them in their programmes for the Development Decade to the extent that they deem fit, requesting, if necessary, the assistance of the World Health Organization for this purpose;
  7. URGES donor countries, which are in a position to provide assistance to developing countries, to increase the level of financial, technical and material assistance provided in the field of health, in order to expedite economic and social progress,

8. REQUESTS the Director-General to transmit this resolution to the Secretary-General of the United Nations with the request to present it to the General Assembly, the Economic and Social Council, the Technical Assistance Committee and the Governing Council of the Special Fund;

9. REQUESTS the Director-General to continue to co-operate with the United Nations and other agencies in the implementation of the United Nations Development Decade.

Thirteenth plenary meeting, 25 May 1962  
A15/VR/13

ANNEX II

STATUS OF HEALTH EDUCATION SERVICES

IN THE

EASTERN MEDITERRANEAN REGION

for

1956, 1958 and 1961

Based on Existing Documents, EMRO

June 1962

Country	Area <sup>1</sup> sq.km.	Popul. <sup>1</sup> in thousands	Governmental Organization in Health								
			Centr. Org. in Health Education			Headed by a qualified <sup>2</sup> H.Educator			Provincial H. Education Activities		
			56	58	61	56	58	61	56	58	61
Aden Protect.	290,080	660	No	No	No	No	No	No			
Cyprus	9,251	558	No	No	OPP <sup>3</sup>	No	No	No			
Ethiopia	1,184,320	21,800	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Iran	1,648,000	20,149	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Iraq	444,442	6,952	No	Yes	Yes	No	No	No	Yes?		
Israel	20,700	2,061			Yes			No			
Jordan	96,610	1,636	No	Yes	No	No	No	No			
Kuwait	15,540	219			Yes			No			
Lebanon	10,400	1,555	Yes	Yes	Yes	No	No	No			
Libya	1,759,540	1,172			No			No			
Pakistan	943,725	86,823	Yes	Yes	Yes	No	No	No	No		some
S.Arabia	1,600,000	6,036	No		Yes	No		No	No		
Somalia	637,661	1,990	No	No	No	No	No	No	No		
Sudan	2,505,823	11,615	IPP <sup>3</sup>	IPP	IPP	No	No	No	No	No	
Syrian Arab Rep.	184,479	4,539		Yes	Yes		Yes	Yes			
Tunisia	125,180	3,935	No	Yes	Yes		No	No		IPP	
UAR	1,000,000	25,365	Yes	Yes	Yes	Yes	Yes	Yes		Yes	
Yemen	195,000	1,500	No	No	No	No	No	No			

<sup>1</sup>UN Demographic Yearbook, 1960

<sup>2</sup>Qualified Health Educator is one who has a post-graduate degree in public health with specialty in health education (MPH, MSPH, or DPH)

<sup>3</sup>IPP In planning process

Education			Existence of Training Facilities or Activities											
Coordination of Education Activities			For Health Educators			For Other Personnel			For Auxiliary Personnel			For Teachers (on R. Education)		
56	58	61	56	58	61	56	58	61	56	58	61	56	58	61
No	No	No	No	No	No	No	No	No		some			some	
some	some	IPP	No	No	No	No	No			some		some	some	
No	some		No	No	IPP	No	some	Yes?	some	Yes	Yes	some	Yes	
Yes	Yes	Yes	some	some	some	some	some	some	Yes	Yes	Yes	Yes	Yes	Yes
some	No		No	No	No	some			some	Yes	Yes	Yes	Yes	Yes
		some	No	No	Yes			Yes				Yes		
No			No	No	No	No	No	No	some	some	some	some		
		No	No	No	No	No	No	No	No	No	No			
No	No		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	some	some	
		No			No			No				No		
No	No		No	No	No	Yes		Yes	Yes		Yes	Yes		
No			No	No	No	No	No	No	some			some		
No	No	No	No	No	No	No	No	No	some?				some	
IPP	No	No	No	No	No	No	No	No	some	Yes	some	some	some	some
			No	No	No						some			
No	No	No	No	No	No		some	No		some	some	some	some	some
Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
			No	No	No	No	No	No				little		

Country	No. of qualified Health <sup>1</sup> Educators in the country (Nationals)			Special Budget Allocation For Health Education		
	56	58	61	56	58	61
Aden Protect.	0	0	0	No	No	
Cyprus	0	0	0	No	No?	
Ethiopia	2?	2?	3	some	Yes	Yes
Iran	6 <sup>+</sup>	10 <sup>+</sup>	15 <sup>+</sup>	Yes	Yes	Yes
Iraq	0	0	0	No	little	
Israel			1 <sup>+</sup>			
Jordan	0	0	0	No		
Kuwait	0	0	0			
Lebanon	0		1	Yes		
Libya	0	0	0			
Pakistan	0		10	Not def.		
Saudi Arabia	0	0	0			
Somalia	0	0	0	No		
Sudan	0	0	0	No	No	
Syrian Arab Rep.	0		1			Yes
Tunisia	0	0	0	No	No	
UAR	2?	3?	3 <sup>+</sup>	Yes	Yes	Yes
Yemen	0	0	0			

<sup>1</sup>In this column the total number of national health educators residing in the country, regardless of their employment, has been listed

R E F E R E N C E

56				58			61	
				EM/HEP.Sem/15	13.10.58			
EM/RC6/Techn.Disc.			3	"	"	"	EM/HEP/14	22.6.61
"	"	"	15	"	"	"	EM/HEP/7	September 1959
"	"	"	2	"	"	"		
"	"	"	8	"	"	"	EM/HEP/17	22.7.61
				"	"	"	EM/HEP/15	22.6.61
"	"	"	5	"	"	"	EM/HEP/16	22.6.61
				"	"	"		
"	"	"	10	"	"	"		
				"	"	"	EM/HEP/12	November 1960
"	"	"	13	"	"	"	EM/HEP/9	December 1959
"	"	"	18	"	"	"		
"	"	"	6	"	"	"		
"	"	"	7	"	"	"	EM/HEP/8	September 1959
				"	"	"	EM/HEP/11	July 1960
				"	"	"	EM/HEP/10	July 1960
"	"	"	4	"	"	"		
				"	"	"		

ANNEX III

THE PROGRAMME OF MENTAL HEALTH IN THE  
EASTERN MEDITERRANEAN REGION  
JANUARY 1962

I INTRODUCTION

The Regional Programme of Mental Health, which was discussed during the Meetings of Mental Health Experts in Alexandria between 19 and 23 December 1960, continues to develop according to plans.

During these meetings the topic of the agenda was intended to deal with the concept of mental health and of its medical, social, economic and widely cultural aspect, to enable the scope to be clear for planning purposes. Moreover, it was intended to enable the workers from different countries to know each other and to communicate their views and share experience during the meeting and afterwards. Another reason was to interest participants in the problems of the Region in general and to enable them to provide advice whenever needed on such subjects. In other words, to draw them outside the limits of their own particular countries of the Region.

In view, however, of the advent of social and economic developments and the subsequent cultural changes coming in their wake, the programme had to be planned on a short-term basis and organized in a manner allowing for flexibility and for modifications made necessary by the trend of emerging experience. In such a fluid state, where the structure of mental health rapidly passes from one phase to another, the order of priority may sometimes become a matter of controversy and of difference of opinion. The emphasis of the worker in the field and the planner in the office may sharply contradict one another.

The deciding factor in priority may become psychological rather than utilitarian and what begins as psychological may end as an urge and loom as a dire need. Moreover, participation of lay public bodies has greatly influenced the trend of health services. It has brought the weight of

demotic (popular) factors to bear at all levels of planning and organization. And as a result, the order of priority and the patterns of health assistance have become affected. In such a phasic mood, it is difficult to insist on any logical order in any national programme which is not fully shared by the Governments. Moreover, and this is true, with the rising "level of aspiration" in the public in their growing confidence in the effectiveness of their role in health and other matters, this has led to programmes which may not possibly be adequate in view of certain technical and budgetary limitations.

The preoccupation with the hospital as a solution of mental health problems is still the order of the day, though we feel that the hospital is not an archetype but a pattern of services which has to follow closely the needs of the community. It is felt that the hospital in its older concept will not possibly serve its newer purpose: it may even defeat it.

Small intra-mural units, functionally linked with the community, and adequate extra-mural services, together with voluntary participation, may provide better facilities for health assistance at the present. This is the specific field in which public participation may indeed constitute a real contribution to technical work, as the local factors may be of paramount importance in personalising and popularising health assistance to the public.

The role of voluntary bodies is not yet fully appreciated by professional people. There are illustrations where in this Region occupational therapy, for example, was for the first time conceived and implemented in a hospital by a soldier and administrator in 1884. More important, even, in this respect, is the fact - which should be more emphasized - that mental health is not entirely technical from the medical point of view and that some of the serious problems of mental health may have their roots in the social, economic or cultural field. This fact clearly indicates that treatment procedure has to be planned on a team basis whenever public participation is enlightened and informed.

The following outline of the three-years' programme, 1961 - 1964, was accepted and is being implemented. This Region is passing through a phase of intensive change and development and therefore the shortage of trained personnel constitutes a serious problem. Moreover, the public demand for better health services is growing rapidly as a result of self-discovery and growing public awareness.

## II TRAINING OF STAFF

### 1. Psychiatrists

The training of psychiatrists abroad and within the Region is progressing. The momentum is not coordinated with the intensity nor the urgency of the need. In some countries the programme of post-graduate training has not yet been revised and brought up to contemporary standards. The ecological concept of mental health has not yet penetrated into the curriculum in some countries. This Office is endeavouring to expand its budget to enable more psychiatrists to have training. Candidates awarded fellowships spend three months at the Lebanon Hospital for Nervous and Mental Disorders in order to familiarise them with the ecological implications and the broader aspect of psychiatry in the West. This system would provide an assessment of candidates and of their suitability for their studies. In fact, an assessment of the two first cases was confirmed by the favourable progress of their studies in the Institute of Psychiatry in London.

In this respect, it is felt that more working links should be established with the Lebanon Hospital and with other regional hospitals with adequate facilities and competent staffing, for the purpose not only of training but also of research, as the nature of some regional problems in mental health may not be amenable for research outside the cultural and environmental context.

## 2. Nurses

Fellowships for higher training of nurses abroad are still granted to suitable candidates and will continue to be granted whenever circumstances make it possible.

In view, however, of the emergency conditions in the Region the need for intensive short-term training as a stop-gap is keenly felt and the programme is being finalized with the Lebanon Hospital for Nervous and Mental Diseases for the training of twelve regional nurses. It was initially decided that a six months' intensive training may qualify candidates for work in some hospitals, especially as in-service tutors - a category of personnel which is greatly needed. An additional month is given for instruction in social techniques and enquiry, to fit them for better community work. At the present evolutionary stage of some countries social work would be more profitable if integrated as part and parcel of the nursing task. Differentiation at the present stage may not serve its purpose. It needs no apology to say that it is felt that the level of promotion of nursing should go hand in hand with the promotion of the community and of the standard of work in general. The ecological concept of social work penetrates the design of social techniques which will be an integral part of the general curriculum of nursing training.

### III MENTAL HEALTH SERVICES FOR CHILDREN

In 1964, the organization of mental health services for children within the framework of paediatric services will be discussed by a small group of experts. It is thought that this could perhaps be carried out in Kuwait, in view of some considerations which are extremely favourable to such a study.

Little has so far been done in the Region for children in this respect and it is felt that the concentration of services was mainly on adults. This Office feels that the children's services have a preventive aspect which is very important.

The nursery in Kyrenia in Cyprus which is run on cheap lines (five shillings a week for working mothers) has illustrated that many of the working class children who joined the nursery with signs of neurosis (such as bed-wetting) recovered very quickly. Furthermore, we feel that this is the only way to raise the standard of living of poor income children as they stay in the nursery from 6 a.m. to 6 p.m. and consequently most of the waking hours of the life of the children are spent in the nursery where the standard of living is very much higher than in their homes.

#### IV THE PROBLEM OF CHRONIC PATIENTS

The problem of chronic patients in mental hospitals has an aspect which may give rise to serious depletion of funds and overcrowding of hospital beds. It seriously antagonises the admission of the early recoverable cases, thus contributing to chronicity by a vicious spiral. For this reason, a small group of specialists is scheduled to be held in 1963 probably in Teheran for the discussion of the subject. Important papers on the management and rehabilitation of chronics have been provided. Special mention must be made, however, of the experience of the Lebanon Hospital of Nervous and Mental Disorders under the leadership of Dr. A.S. Manugian, where a special unit for chronics with a specially trained staff has been working for some time with excellent results.

#### V REGIONALIZATION OF TRAINING CENTRES

In the experience of this Office, different countries of the Region could make a great contribution to the different aspects of mental health programmes of training, as such a contribution is generally dependent on the historical, cultural and other potentialities, which may contribute more to the promotion of one project than another. In Pakistan and Tunisia, for example, a real contribution to the social studies and techniques may be made. Pakistan is in fact ideal for demographic studies on problems of population increase. Iran may provide the best possibilities in the Region for

occupational and rehabilitational therapy because of the traditions of art and craft. On the other hand, in view of certain historical and contemporary factors, the Lebanon may be able to give a valuable contribution in the training of personnel and the United Arab Republic in drug addiction, recreational therapy, etc. Finally, Kuwait is in possession of important factors which may enhance a heightened validity of epidemiological studies. The resources of other countries give a useful impression and this Office is working on such an analysis.

#### VI SOCIAL WORK AND CLINICAL PSYCHOLOGY

The definition and elaboration of the ecological concept in social work and clinical psychology, including psychometrics, will be the topic for a small conference in 1964. It should be stressed that the aim of this meeting would be to integrate the experience in this field which has been tested and made valid in the light of cultural experience.

#### VII PROVINCIAL SERVICES

There is growing need for the extension of psychiatric services into the provincial and rural areas, especially those where great agricultural developments are occurring. It is viewed by this Office that the agricultural developments in some regions may constitute in reality an agricultural revolution parallel in effect to the industrial revolution in Europe. It is believed that as an initial step a general duty doctor may be the proper spearhead for such services. A six months' training course in mental health for suitable medical officers working in the provinces may enable them to deal with and assess the situation in advance and so prepare the soil for more specialized planning. This may, however, involve the real risk that the general practitioner may lose his orientation and perspective by inadvertently assuming the role of a specialist. For this reason, training in the Region may be more appropriate.

#### VIII REORGANIZATION OF MENTAL HOSPITALS

Mental hospitals which have exhausted their potentialities in lagging behind the community in action are real problems. In the experience of this Office it is futile to deal with one aspect of reform, e.g. staff, buildings or accommodation. Early in 1961 a team of one expert and one experienced nurse were sent to such a hospital where they worked and studied for one month and recommendations given in their report are of extreme interest and are likely to prove a pattern to be used for the reorganization and modernization of such hospitals in the Region.

#### IX EPIDEMIOLOGICAL STUDIES

It is expected that late in 1963 or early 1964 epidemiological methods and techniques will be the topic of a demonstrative study to enable the Office to make a contribution to the unification of methods so that the information could be exchanged on a basis of understanding. Notwithstanding this we are aware of the implications of such studies and the risk of utilizing the results for planning before it is possible to exclude all the fallacies inherent in its application in psychiatry.

#### X RESEARCH

The feeling is growing that research cannot be divorced here from the daily activity of the clinician. More emphasis should be given to techniques rather than practice. In any pioneering work more emphasis should be given to techniques rather than practice. Methodology and techniques have to be tested and formalized before community practice is seriously organized. In view of the different cultural and social backgrounds some of the imported methods and techniques of study, investigation and therapy may not work properly and may need revision and adaptation, as is the case in psychometrics, analytical therapies, etc. Apart from research directed towards the cultural aspect and in relation to aetiology, symptomatology therapy, etc., there are specific problems, e.g. the role of viruses and parasitic conditions as

aetiological factors. Indeed, it has been found that the spread of African horse sickness in 1960 in one country coincided with the incidence of neuro-psychiatric cases of doubtful aetiology; in another country there is strong support for the belief that there is a relationship between mental health and entomological and virological factors.

Psychiatry cannot easily be transplanted across barriers of language, culture and environment and the psychiatrist should have the capacity to create and develop adequate systems which enable him to attune his mind to the problems of his patients in terms of their own level. The deeper psychological experiences of mankind have such anthropological, psychological and sociological dimensions as to make a very intimate understanding of background and cultural pattern absolutely essential.

#### XI MENTAL HEALTH AND PUBLIC HEALTH

There is a growing feeling that mental health and public health should be more effectively coordinated in work since some of the important mental health problems in this Region are of public health nature. Moreover, the gradual penetration of epidemiological work, school and industrial health and domiciliary services into the mental health system has made it necessary that the experience and some of the techniques of the public health man should be adopted whenever possible. Moreover, to augment the concept of the unity of the mind and body such an association is inescapable.

ANNEX IV

PROJECTS BY COUNTRIES

The following statement shows the status of projects in the Eastern Mediterranean Region as of 30 June 1962:

- Planning - Funds designated and included in current programmes (1962-1964)
- In Operation - WHO staff in the field
- Completed - International staff or other WHO assistance withdrawn (including all projects completed between 1.7.61. and 30.6.62.)
- TA - Technical Assistance Funds (Category I only)
- Regular - Funds from WHO Regular Budget
- UNICEF - Funds from United Nations Children's Fund
- Other - Funds-in-Trust, etc.

Country	No.	Project	Source of Funds	Status
ADEN	2	Maternal and child health, Aden Protectorate	Regular/ UNICEF	Planning
CYPRUS	1	Nursing education	TA	Planning
	6	Tuberculosis control	TA	Planning
	10	Leprosy control	TA	Planning
	11	Rural health	Regular	Planning
	12	Veterinary public health	Regular	Planning
	13	Public health administration	TA	Planning
	15	Public health laboratory	Regular	Planning

Country	No.	Project	Source of Funds	Status
ETHIOPIA	2	Leprosy control	TA/UNICEF	Planning
	3	Public health administration	TA	Planning
	4	Venereal diseases control	TA/UNICEF	Planning
	6	Tuberculosis control	TA/UNICEF	In Operation
	9	Health training centre, Gondar	Regular/UNICEF	In Operation
	14	Malaria pre-eradication programme	MESA	In Operation
	17	Medical education	Regular	Planning
	23	Maternal and child health, Eritrea	TA/UNICEF	In Operation
	25	Supervisory team for health centres	Regular/UNICEF	In Operation
	29	Training course for X-ray technicians	TA	Planning
	30	Nutrition consultant	Regular/UNICEF	Planning
IRAN	1	Malaria eradication	MESA/TA/UNICEF	In Operation
	7	Nutrition institute	TA/UNICEF	In Operation
	21	Midwifery education	Regular/UNICEF	Completed
	25	Communicable eye diseases control	TA/UNICEF	Planning
	26	Public health laboratory	Regular	In Operation
	28	Mental health	Regular	In Operation
	30	Industrial and occupational health	TA	Planning
	37	Nursing education, Red Lion and Sun School of Nursing, Rey	TA	In Operation

Country	No.	Project	Source of Funds	Status
IRAN (Contd.)	38	Bilharziasis control	TA	In Operation
	42	School of physiotherapy, Shiraz	Regular	In Operation
	43	Assistance to provincial faculties of medicine	Regular	Planning
	45	Air pollution control	Regular	Planning
	47	Rehabilitation Centre, Jamalabad, Teheran	Regular	Planning
	48	Medical social work	TA	Planning
	50	Training school for sanitarians (Palasht School)	TA/UNICEF	Planning
	52	Post-basic nursing education	Regular	Planning
IRAQ	11	Malaria eradication	MESA/Regular UNICEF	In Operation
	15	Bilharziasis control	TA	In Operation
	18	Communicable eye diseases control	Regular/ UNICEF	In Operation
	23	School health services	TA/UNICEF	Planning
	33	College of Medicine, Baghdad	Regular	Completed
	34	Vital and health statistics	Regular	Planning
	35	Training of health personnel	TA/UNICEF	In Operation
	37	College of Nursing, Baghdad	Regular/ UNICEF	Planning
	38	Public health laboratory	Regular	Planning
	40	Hospital administration	TA	Planning
	42	Public health advisory services	TA	Planning
43	Cancer control	Regular	Planning	
ISRAEL	5	Malaria eradication	MESA	In Operation
	24	Child psychiatry and mental health	Regular	In Operation

Country	No.	Project	Source of Funds	Status
ISRAEL (Cont'd.)	25	Hadassah Medical School, Jerusalem - (A) Anatomy	Regular/ Reimbursable	In Operation
	26	Hospital administration	TA	Planning
	29	Hadassah Medical School, Jerusalem - (B) Preventive and social medicine	Regular	In Operation
	32	Evaluation of a national health programme	TA	Planning
JORDAN	6	Malaria eradication	MESA/TA UNICEF	In Operation
	11	Communicable eye diseases control	TA/UNICEF	Planning
	21	School health services	Regular	Planning
	23	Production of vaccines	Regular/ UNICEF	Planning
	24	Assistance to Children's Hospital, Amman	TA/UNICEF	In Operation
	25	Public health advisory services	Regular	Planning
	27	Sanitary engineer for municipal water supplies	TA	In Operation
	28	Rehabilitation services	Regular	Planning
	29	Tuberculosis control (National Pilot Area)	Regular/ UNICEF	Planning
	30	Virology laboratory	Regular	Planning
KUWAIT	1	Tuberculosis control	Regular	In Operation
	2	Communicable eye diseases control	Regular	Planning
	8	Public health advisory services	Regular	Planning
LEBANON	4	Rural health unit	TA/UNICEF	In Operation
	7	Malaria eradication	MESA/UNICEF	In Operation

Country	No.	Project	Source of Funds	Status
LEBANON (Contd.)	10	Nursing education	Regular	Planning
	17	Environmental health	TA	Planning
	24	Medical use of radioisotopes	Regular	Planning
	25	Industrial and occupational health	TA	Planning
	31	Rehabilitation of the physically handicapped	Regular	Planning
	34	Dental health	TA	Planning
	39	American University, Beirut	Regular	In Operation
	41	Blood bank	Regular	Planning
	42	Municipality health services	Regular	Planning
	45	Bilharziasis control	TA	Planning
LIBYA	2	Maternal and child health, Tripolitania	Regular/ UNICEF	Planning
	3	Nursing education, Tripoli	Regular/ UNICEF	In Operation
	6	Communicable eye diseases control	Regular/ UNICEF	Planning
	7	Health Training Institute, Benghazi	TA/UNICEF	In Operation
	9	Malaria eradication	MESA	In Operation
	12	Maternal and child health, Cyrenaica	TA/UNICEF	In Operation
	22	Tuberculosis control (National Pilot Area)	TA/UNICEF	In Operation
	23	Health centre, Fezzan	Regular	Planning
PAKISTAN	22	Sanitary engineering, West Pakistan	TA	In Operation
	23	Children's Hospital, Karachi	Regular/ UNICEF	Completed



Country	No.	Project	Source of Funds	Status
SAUDI ARABIA	4	Malaria pre-eradication programme	MESA/F-in-T	In Operation
	5	Environmental health	TA	In Operation
	7	Public health laboratory	Regular	Planning
	11	Maternal and child health	TA/F-in-T	Planning
	13	Tuberculosis control (National Pilot Area)	Regular/ UNICEF	Planning
	15	Health Assistants' and Sanitarians' Institute, Riyadh	Regular	In Operation
	20	Communicable eye diseases control	F-in-T	Planning
	23	Public health advisory services	TA	In Operation
	26	Community development (Health aspects)	Regular	Completed
	28	Health survey	Regular/ F-in-T	Planning
	29	Basic public health and medical care services	Reimbursable	Planning
	30	Smallpox eradication	Regular	Planning
	31	Nursing adviser to the Government	TA	Planning
32	Meat conservation	Regular	Planning	
SOMALIA	2	Malaria pre-eradication programme	MESA/TA	In Operation
	8	Training of health personnel	Regular/ UNICEF	In Operation
	11	Tuberculosis control	TA/UNICEF	In Operation
	13	Basic health services	TA	In Operation
	14	Public health advisory services	Regular	In Operation
15	Training of nursing personnel	TA/UNICEF	In Operation	

Country	No.	Project	Source of Funds	Status
SOMALIA (Contd.)	16	Leprosy control	TA	Planning
	19	Smallpox control and eradication	TA	Planning
	20	Organization of medical care	TA	In Operation
	21	Management of medical stores and pharmacy	TA	Planning
	22	Communicable eye diseases control	Regular	Planning
SUDAN	6	Malaria pre-eradication programme	MESA	In Operation
	7	Nursing education, Khartoum	Regular	In Operation
	9	Tuberculosis control demonstration and training centre, Wadi Medani	TA	Completed
	12	Leprosy control	Regular/ UNICEF	Planning
	15	Communicable eye diseases control	TA/UNICEF	Planning
	16	Venereal diseases control	TA/UNICEF	Planning
	17	Dental assistants' training	Regular	In Operation
	19	Rural health demonstration area	TA/UNICEF	In Operation
	26	Onchocerciasis control	Regular	Planning
	28	Smallpox eradication	Regular	Planning
30	Radiation and isotopes services (Khartoum)	Regular	Planning	
32	Malaria eradication training centre	MESA	Planning	
34	Drug control	Regular	Completed	
SYRIAN ARAB REPUBLIC	2	Malaria eradication	MESA/TA/ UNICEF	In Operation
	4	Bilharziasis control	Regular	Planning

Country	No.	Project	Source of Funds	Status
SYRIAN ARAB REPUBLIC (Contd.)	15	Vital and health statistics	Regular	Completed
	16	Rural health unit	TA/UNICEF	In Operation
	20	Communicable eye diseases control	Regular	Planning
	30	Public health and endemic diseases laboratory	Regular	Planning
	32	Blood bank	Regular	Planning
	33	Cancer control	Regular	Planning
	34	Rural environmental sanitation	Regular	Completed
	37	Nursing education, Damascus	Regular/ UNICEF	In Operation
	39	Training of sanitarians	TA	Planning
	45	Tuberculosis control (National Pilot Area)	Regular/ UNICEF	Planning
TUNISIA	3	Communicable eye diseases control	TA/UNICEF	Planning
	6	Maternal and child health	TA/UNICEF	In Operation
	17	Malaria eradication	MESA/TA	Planning
	18	Environmental health	TA	In Operation
	20	Public health laboratory	Regular	Planning
	22	Ophthalmological centre, Tunis	Regular	In Operation
	24	Tuberculosis control	Regular/ UNICEF	Completed
	26	Production of pharmaceuticals	Regular	Planning
	27	Medical education	Regular	Planning
	29	Medical rehabilitation centre	TA/UNICEF	Planning
	30	Venereal diseases control	Regular	Completed
31	Training of health personnel	Regular	Planning	

Country	No.	Project	Source of Funds	Status
UNITED ARAB REPUBLIC	23	Malaria eradication	MESA/UNICEF	Planning
	27	High Institute of Public Health, Alexandria	Regular	In Operation
	30	Premature infants' unit	Regular/ UNICEF	Planning
	35	Nutrition institute	TA/UNICEF	Planning
	37	Virology research laboratory	Regular	Planning
	38	Centre for sanitary engineering research of the University of Alexandria	TA	Planning
	44	Concentrated sera production plant	TA	Planning
	48	Drug control laboratory	TA	Planning
	49	Bilharziasis control pilot project and training centre	Regular/ UNICEF	In Operation
	50	Nursing education	TA/UNICEF	In Operation
	51	Rehabilitation of tuberculous patients	Regular	Planning
	52	Dried smallpox vaccine production	Regular	Planning
	55	Rural health study	TA/UNICEF	Planning
	57	Audiometric centre for school children	TA	Planning
YEMEN	3	Public health administration	Regular	In Operation
	4	Malaria pre-eradication programme	MESA	Planning
	7	Maternal and child health	Regular	Completed
	8	Health centre and training school, Sana'a	TA/UNICEF	In Operation
	13	Communicable eye diseases control	Regular	Planning

Country	No.	Project	Source of Funds	Status
YEMEN (Contd.)	15	Local health services (a) Health centre, Hodeida (b) Health centre, Taiz	Regular/ UNICEF	Planning
	16	Smallpox eradication	Regular	Planning
INTER- COUNTRY PROJECTS	5	Higher Institute of Nursing, University of Alexandria	TA/UNICEF	In Operation
	7	Arab States Training Centre for Education in Community Development	TA	In Operation
	19	Regional malaria eradication training centre	MESA	In Operation
	22	Adviser in health education	Regular	In Operation
	34	Sanitary engineering, field training	Regular	Completed
	36	Group meeting on vital and health statistics	Regular	Planning
	38	Seminar on food hygiene and zoonoses control and veteri- nary public health practice	Regular	Planning
	42	Medical education conference	Regular	Planning
	43	Advisory services	Regular	In Operation
	44	Medical literature	Regular	In Operation
	45	Participation in educational meetings	Regular	In Operation
	50	Seminar on training of auxiliary health personnel	Regular	Completed
	51	Epidemiological and statistical centre	Regular	In Operation
	53	Virology training	Regular	Planning
55	Assistance to medical libraries	Regular	Planning	
56	Community water supply	Regular/ CWSSA	Planning	

Country	No.	Project	Source of Funds	Status	
INTER-COUNTRY PROJECTS (Contd.)	58	Malaria eradication evaluation team	MESA/ Regular	In Operation	
	59	Regional study on diarrhoeal diseases	Regular	Planning	
	60	Group fellowships in public health administration (USSR)	TA	Planning	
	61	Training course for laboratory technicians	Regular	In Operation	
	62	Training course for X-ray technicians	TA	Planning	
	63	(a)	Training course for general practitioners	Regular	Planning
			(b) Training course for psychiatric nurses	Regular	Planning
	66	Rural housing	Regular	Planning	
	71	Regional conference on malaria eradication	MESA	Planning	
	72	Training course for waterworks engineers	Regular/ CWSSA	Planning	
	74	Meeting on rehabilitation of chronic psychiatric patients	Regular	Planning	
	75	National tuberculosis training centre with regional training programme	Regular/ UNICEF	In Operation	
	76	Pharmaceutical and medical stores adviser	Regular	Planning	
77	Group meeting on community water supply	Regular/ CWSSA	Planning		
78	Seminar on tuberculosis in infancy and childhood	Regular	Planning		

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Country	No.	Project	Source of Funds	Status
INTER- COUNTRY PROJECTS (Contd.)	79	Advanced training for sanitarians	TA	Planning
	82	Regional group meeting on child psychiatry	Regular	Planning
	84	Consultants on medical education	Regular	Planning
	87	Travelling seminar for public health administrators	Regular	Planning
	88	Smallpox eradication	Regular	Planning

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ANNEX V

AGREEMENTS SIGNED BETWEEN 1 JULY 1961 AND 30 JUNE 1962

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ADEN PROTECTORATE- UNICEF/3	Basic Maternal and Child Welfare Services Addendum I to plan of operation
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CYPRUS 1	Nursing Education Exchange of letter Services Nurse Educator
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ETHIOPIA	The basic agreement between the Government of Ethiopia and WHO was concluded in January 1962
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ETHIOPIA 2	Leprosy Control Addendum I to plan of operation
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ETHIOPIA 16	Communicable Eye Diseases Control Addendum I to plan of operation
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ETHIOPIA 26	Mental Health Exchange of letter Short-term consultant
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IRAN 1	Malaria Eradication Exchange of letter Extension plan of operation
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IRAN 43	Assistance to Provincial Faculties of Medicine Exchange of letter Recruitment of WHO staff
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IRAQ	The basic agreement between the Government of Iraq and WHO was concluded in October 1961
IRAQ 11	Malaria Eradication Addendum I to plan of operation
IRAQ 18	Communicable Eye Diseases Control Plan of operation
IRAQ 33	Assistance to College of Medicine, Baghdad Exchange of letter
IRAQ 37	High Institute of Nursing, Baghdad Exchange of letter Short-term consultant
IRAQ 41	Drug Control Exchange of letter Short-term consultant
ISRAEL 5	Malaria Eradication Plan of operation
ISRAEL 26	Hospital Administration Exchange of letter Short-term consultant
ISRAEL-UNICEF/1	Maternal and Child Welfare Services Plan of operation
ISRAEL-UNICEF/6	Nutrition Plan of operation

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JORDAN 6	Malaria Eradication Addenda I and II to plan of operation
JORDAN 23	Production of Vaccines Plan of operation
JORDAN 24	Assistance to Children's Hospital, Amman Plan of operation
KUWAIT 1	Tuberculosis Control Plan of operation
LEBANON 7	Malaria Eradication Addendum III to plan of operation
LEBANON 21	Hospital Administration Exchange of letter Short-term consultant
LEBANON 43	Mental Health Exchange of letter Short-term consultant
LEBANON 44	Drug Control Exchange of letter Short-term consultant
LIBYA	The basic agreement between the Government of Libya and WHO was concluded in June 1962
LIBYA 2	Maternal and Child Health, Tripolitania Addendum I to plan of operation
LIBYA 3	Nursing Education, Tripoli Addendum I to plan of operation

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LIBYA 7	Health Training Institute, Benghazi Addendum I to plan of operation
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LIBYA 12	Maternal and Child Health, Cyrenaica Addendum I to plan of operation
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PAKISTAN 13	Tuberculosis Control (BCG) 9th Addendum to plan of operation
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PAKISTAN 36 (c)	Malaria Eradication Plan of operation
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PAKISTAN 38	Nutrition Survey Plan of operation
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PAKISTAN 39	Leprosy Control Plan of operation
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PAKISTAN 40	Communicable Eye Diseases Control Plan of operation
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PAKISTAN 41	Smallpox Eradication Exchange of letter Short-term consultant
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PAKISTAN 43	Vital and Health Statistics Plan of operation
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PAKISTAN 49	Assistance to Malaria Training Centres Addendum I to plan of operation
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PAKISTAN/UNICEF/2	Maternal and Child Welfare Centres Addendum V to plan of operation
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PAKISTAN/UNICEF/17	Rural Health Addendum I to plan of operation
SAUDI ARABIA 4	Malaria Eradication Exchange of letter Extending plan of operation
SAUDI ARABIA 26	Community Development (Health Aspects) Exchange of letter Short-term consultant
SOMALIA	The basic agreement between the Government of Somalia and WHO was concluded in January 1962
SOMALIA 2	Malaria Eradication Plan of operation
SUDAN	The basic agreement between the Government of Sudan and WHO was concluded in March 1962
SUDAN 15	Communicable Eye Diseases Control Plan of operation
SUDAN 19	Rural Health Demonstration Areas Plan of operation
SUDAN 34	Drug Control Exchange of letter Short-term consultant
SYRIA 2	Malaria Eradication Addendum I to plan of operation

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SYRIA 39	Training of Sanitarians Exchange of letter Recruitment Sanitary Tutor
TUNISIA 3	Communicable Eye Diseases Control Addendum VI to plan of operation
TUNISIA 6	Maternal and Child Health Addendum I to plan of operation
TUNISIA 8	Nutrition and School Feeding Addenda I and II to plan of operation
TUNISIA 18	Environmental Health Exchange of letter Recruitment Sanitary Engineer
TUNISIA 20	Public Health Laboratory Exchange of letter Short-term consultant
TUNISIA 22	Ophthalmological Centre, Tunis Exchange of letter Extending validity of plan of operation
TUNISIA 27	Medical Education Exchange of letter To cover Fellowships
TUNISIA 28	Tuberculosis Chemotherapy Pilot Project Exchange of letter Short-term consultant

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UAR-EGYPT 25 (II)	Communicable Eye Diseases Control Addenda I and II to plan of operation
UAR-EGYPT 44	Concentrated Sera Production Plant Exchange of letter Short-term consultant
UAR-EGYPT 50	Nursing Education Plan of operation
UAR-EGYPT 52	Dried Smallpox Vaccine Production Exchange of letter Equipment and supplies
YEMEN 8	Health Centre and Training School, Sana'a Addendum I to plan of operation
YEMEN 16	Smallpox Control and Eradication Plan of operation
EMRO 56	Community Water Supply Exchange of letter with Pakistan Government
EMRO 61	Training Course for Laboratory Technicians Plan of operation with Lebanese Government

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