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REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN

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CHAIRMAN: H.E. Ato Markos Agajyelew

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Government	Representative, Alternate or Adviser
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FRANCE	Médecin Colonel Henri Morin
ISRAEL	Dr. R. Gjebin Mr. M. Bavly
UNITED KINGDOM	Dr. P. Dill-Russell

World Health Organization

Secretary to the Sub-Committee	Dr. A.H. Taba, Regional Director
Representative of the Director-General	Dr. F. Grundy, Assistant Director-General

Representatives of United Nations and Subsidiary Bodies

UNITED NATIONS UNITED NATIONS TECHNICAL ASSISTANCE BOARD AND SPECIAL FUND	Mr. Gary Hampton
INTERNATIONAL LABOUR OFFICE	Mr. Amoni

Representatives and Observers of International Non-Governmental Organizations

INTERNATIONAL DENTAL FEDERATION	Mr. C.L. Bouvier	(Representative)
INTERNATIONAL COUNCIL FOR JEWISH SOCIAL AND WELFARE SERVICES	Dr. A. Gonik	(Representative)
INTERNATIONAL ASSOCIATION FOR PREVENTION OF BLINDNESS	Dr. F. Amman Professor D. Klein	(Representative) (Representative)
INTERNATIONAL COUNCIL OF NURSES	Miss M.J. Marriott	(Representative)
WORLD MEDICAL ASSOCIATION	Dr. Jean Maystre	(Representative)
LEAGUE OF RED CROSS SOCIETIES	Dr. H. Zielinski	(Representative)
INTERNATIONAL COMMITTEE FOR MILITARY MEDICINE AND PHARMACY	Dr. J. Voncken	(Representative)

1. PROPOSED PROGRAMME AND BUDGET ESTIMATES FOR 1967 FOR THE EASTERN MEDITERRANEAN REGION: Item 8 of the Agenda (document EM/RC15/3).

The REGIONAL DIRECTOR, introducing the proposed programme / and budget estimates for 1967, said that the document before the Sub-Committee consisted of the introduction, a summary by main subjects, sections on the Regional Office, regional advisers, WHO representatives, country programmes, and three annexes.

The introduction (pages vi-x) explained how the document was prepared. It would be noted that the tables given in each section of the document were prefaced by an explanatory narrative. The three columns in each table referred respectively to the regular budget, the technical assitance budget, and other extra budgetary funds. It was the regular budget which would most concern the Sub-Committee at its present meeting since the technical assistance programme for 1967 would only subsequently be prepared by governments within their 1967-1968 biennium programmes. The figures given under the technical assistance columns should, therefore, be regarded as tentative although they did represent what it was felt the various governments would wish to see included in their consolidated Expanded Programme of Technical Assistance but, if necessary, a change could be made. As far as the regular budget was concerned, it would be noted that the total figure given under the 1967 column represented an increase of approximately 8.97% over the previous year, about 95% of which would be spent on field projects.

In the technical assistance column of the budget were also included projects to be financed by a "Funds-in-Trust" arrangement, whereby the entire cost was reimbursed by the governments concerned. A number of such projects had been implemented in Saudi Arabia and Libya, where they were growing in importance, as well as in Israel.

The Sub-Committee's attention was directed to the figures given under the 1967 columns. In visiting various countries and in discussions with delegates at the Health Assembly, the opportunity had always been taken to review the programme with the government officials concerned and their views and requests had been taken into consideration when drawing up the programme for 1967.

The provisions under the section relating to the Regional Office were much the same as for previous years and there was no basic or structural change. Under the section relating to regional advisers, it was

proposed to delete the post of communicable disease eye-control adviser since most of the countries concerned were now dealing with the matter themselves. It was proposed to appoint a second nursing adviser to the Advisory Panel as the number of nursing programmes had increased considerably. The post of pharmaceutical and medical stores adviser had merely been transferred from the inter-country programme to the regional panel and there was no actual increase in posts.

The first annex related to the malaria accelerated programme and the second to the community water supply programme. The execution of both programmes was subject to the availability to WHO of additional voluntary funds. The third annex listed in its green pages additional projects which it had not been possible to include in the proposed programme and budget estimates due to lack of funds. If funds became available, however, some of the projects would be implemented in due course and after consultation with governments.

Lastly, the Regional Director said that he would welcome comments, particularly with regard to the general contents and context of the proposed programme.

Dr GJEBIN (Israel), referring to page XII of the proposed programme and budget, asked why an amount of $ 10 700 had been included for venereal diseases and treponematoses for 1967 when there had been no allocation for either of the years 1965 and 1966.

The REGIONAL DIRECTOR replied that although there had been a slight upward trend in the incidence of venereal diseases in the Region - as in the rest of the world - most countries of the Region did not require assistance from WHO but carried out this type of activities on their own. Advice had, however, been given to two countries with venereal diseases and non-venereal treponematoses problems; and there were sometimes requests for fellowships for specialists to go to other countries which were met under the fellowship programme. The venereal disease aspect as such was not serious and was not expected to become so. However, the specific provision in 1967 which was mentioned by Dr Gjebin was designed to assist the Government of Somalia in an exploratory survey of the incidence of syphilis.

The CHAIRMAN, in the absence of further comment, read out the following draft resolution:

" The Sub-Committee,

Having examined the proposed Programme and Budget Estimates for 1967 as submitted by the Regional Director in document EM/RC15/3;

Appreciating that the proposals for 1967 under the Technical Assistance Programme are tentative in nature until formally included by governments in their consolidated requests to the Technical Assistance Board, except to the extent already forming part of approved continuing projects,

1. FINDS that the programme proposals ensure a suitable balance between the major subject headings as well as between Country and Inter-Country projects;

2. NOTES with satisfaction the continued support to the control of communicable diseases including malaria eradication activities, the further strengthening of public health administration, environmental health and education and training, while due regard having been given to newer fields;

3. ENDORSES the proposed programme and budget for 1967 under the Regular Budget of the World Health Organization, and

4. THANKS UNICEF for its assistance to the health programmes in the Region and welcomes its valuable support also in 1967 and future years.

The draft resolution was adopted.

2. TECHNICAL MATTERS: Item 10 of the Agenda

(c) Problems of cholera control in the Eastern Mediterranean Region with special reference to El Tor type (doc.EM/RC15/8).

The REGIONAL DIRECTOR said that El Tor type cholera had spread westward in the Region beyond the former endemic areas and was a serious problem to the Governments concerned. Iran had adopted strict measures to eradicate it from the eastern part of the country. Other countries were anxious for information on the epidemiology of the disease. He invited Dr Ansari, Acting-Director, Division of Communicable Diseases at Headquarters to speak on the subject.

Dr ANSARI (Division of Communicable Diseases) said that the reporting of the El Tor variety of cholera had not been made compulsory under the International Sanitary Regulations until 1962. The strain of vibrio had first been isolated in 1905 among pilgrims to Mecca in a quarantine camp called El Tor on the Red Sea, but although it was very similar to V.cholerae in its morphological and biochemical characteristics it was considered less virulent to man and was not causing widespread epidemics. Except in rare circumstances, for instance during the second World War, the El Tor vibrio had not been found during epidemics of cholera-like diseases and until 1961 it had seemed to be confined to the Celebes Islands where, in endemic form, it caused serious disease and death. Between 1961 and 1964 it had gradually invaded Indonesia, Hong Kong, the Philippines, Taiwan, Korea, Japan, Malaysia, Singapore, Burma, Thailand, Cambodia, Viet-Nam, East and West Pakistan and India. Simultaneously, classical cholera had occurred in India and Pakistan without any apparent tendency to spread to other countries. During that period, an average of 40 000 cases of classical cholera and 12 000 of El Tor had been reported annually, and in 1964 a total of about 80 000 cases and 20 000 deaths had been reported. The actual number had probably been higher since many countries reported only bacteri logically proven cases. Cholera infection did not always appear in the text-book form; it often occurred with mild clinical symptoms which might be overlooked by Public Health Authorities, and the disease might invade a new area and remain unrecognised for some time.

In 1965, cholera had remained endemic in South East Asia, and El Tor had invaded new territories including middle Asia, Afghanistan, Iran and the Union of Soviet Socialist Republics. In Iran, where 2 115 cases and 300 deaths had been reported up to 21 August, the pattern appeared to be endemo-sporadic. The mode of contamination was contact between persons, and there was no evidence that the outbreak was water-borne. A WHO cholera team was co-operating with the Iranian Government in work of epidemiology, bacteriology, prevention and training. Nearly 3 million people had been vaccinated and 700 centres were working for vaccination of the whole country. The number of fresh cases and the tendency to extend to new areas were diminishing. The coming weeks would be crucial in the matter of spread to non-infected areas.

The effective measures of control against cholera epidemics required extensive epidemiological knowledge and investigation. Until comparatively recently, many vital factors in the transmission of the disease - such as the differential diagnosis of the germ, its growth and survival in the environment, contamination of food and water, the influence of carriers - had been subject to controversy; the pathogenesis of the disease had not been fully understood, and the protective value of vaccines needed critical testing. In recent years, however, important progress had been made in solving some of those problems - particularly in bacteriological techniques and phage typing which had helped in differentiating between vibrio cholera and vibrio El Tor. Studies on carriers, under the joint auspices of WHO and the Governments of the Philippines and Japan, had shown that the carrier stage in cholera extended sometimes for as long as 15 months. Histopathological studies had revealed that tubular vacuolarisation corresponding to hypokalaemia necrose of the kidney caused the clinical aspect of cholera; and a physiological study of fluid absorption had shown that sodium could not be absorbed from the intestine in cholera but that water and potassium could. On the basis of those findings, the correct rehydration for restoring electrolyte balance had been devised, the method consisting of saline infusion controlled by plasma specific gravity determination, the rectification of acidosis by sodium bicarbonate infusion, and the administration of potassium and glucose when indicated.

An extensive controlled field trial with vaccines prepared from classical cholera vibrios and El Tor vibrio on over half a million people in the Philippines had demonstrated that the vaccines gave moderate protection against El Tor infection for about six months. New trials were being conducted in India and the Philippines. Results were expected early in the coming year from international laboratory studies on cholera vaccines with a view to improving their protective value and their standardization.

The WHO Reference Laboratory had assisted studies on phage-typing, the genetics of vibrios, experimental cholera immunology and physiopathology with a view to improved diagnosis, prophylaxis and treatment. Genetic changes in the vibrio could alter its immunological pattern and its susceptibility to antibiotics.

The Organization's policy had been based on the recommendations of the Expert Committees on Cholera and international quarantine, and on the

decisions of the World Health Assembly. The two main aspects of its activities were: immediate assistance on an emergency basis in case of an outbreak; and long-term activities to establish and implement national and international programmes. In the case of outbreaks, emphasis was placed on early detections, prompt diagnosis and effective treatment. In the long-term programme, particular attention was paid to epidemiological studies of factors contributing to the endemicity of cholera, to mass vaccine programmes and to environmental sanitation.

The REGIONAL DIRECTOR further suggested that, with the recent westward spread of Cholera El Tor, it would be timely to assist governments in the strengthening of their public health Laboratory services, as far as prompt bacteriological diagnosis of cholera vibrio and El Tor Cholera is concerned. He therefore proposed that WHO EMRO should sponsor an advanced training course on the bacteriological diagnosis of the classical and El Tor Cholera with participation of those interested countries of the Region, together with Turkey from the WHO European Region; and an inter-regional seminar on the epidemiology and bacteriology of cholera, including El Tor type, with the participation of the Eastern Mediterranean Regional countries and other concerned Regions of the Organization.

The CHAIRMAN invited the Representatives to comment on the subject.

Dr DILL-RUSSELL (United Kingdom) asked how the disease has been transmitted in the Iran epidemic, since it was not water-borne.

Dr ANSARI replied that since no vibrio had been found in the water it was assumed that transmission had been by contact - usually fingers - by contaminated food and by flies. No vibrio had been found in flies but as they had been found in other countries it has been thought that the same might be possible in Iran.

Dr GJEBIN (Israel) enquired if the cases have been concentrated in one area.

Dr ANSARI said that the pattern had been endemo-sporadic, or scattered. There had been numerous cases in the eastern part of the country, but as a whole the incidence was scattered over the northern and eastern parts near the Afghanistan border. The disease had probably been transmitted by road.

The REGIONAL DIRECTOR added that the epidemic had not yet extended beyond the eastern region, but several provinces near the frontiers with Pakistan, Afghanistan and the USSR were affected.

Dr. GRUNDY, Assistant Director-General, asked if it was possible to obtain a reliable estimate of the extent to which correction of the dehydration and electrolyte balance reduced the fatality rate. Although secondary to epidemiology, it was a significant factor because the fatality rate in untreated cases could be as much as 20 per cent. or 25 per cent.

Dr. ANSARI said that in the Bangkok epidemic in 1961 and 1962 it had been found that the fatality rate depended on early detection and early hospitalization. Although time was vital, it appeared that when a good electrolyte balance has been restored, the fatality rate, which was normally about 10 per cent. was reduced to between three and five per cent.

The REGIONAL DIRECTOR said that as the question of cholera had been added to the agenda as a supplementary item, no draft resolution had been prepared. He suggested that a resolution should be prepared to include his suggestions and submitted to the Committee for adoption at the following meeting.

It was so agreed

(a) Epidemiological Aspects of Malaria Eradication in the Eastern Mediterranean Region (EM/RC15/4)

Dr. GRAMICCIA, Chief of Epidemiological Assessment, said that malaria eradication was not difficult in the Eastern Mediterranean Region because it was seasonal; but because malaria was dangerous, eradication must be carried out with particular care. The failure to apply fully certain standards worked out by epidemiologists and to assess the Malaria Eradication Programme on a total coverage basis was one of the most serious obstacles to eradication. Epidemiology was based on traditional observations: the pattern and the limits of the spread of malaria in a country; what were good methods of attack; continuous reporting at the attack phase to see if the expected results were being obtained and to suggest remedial measures when necessary. It was through epidemiological assessment that the final goal of eradicating malaria could be achieved. Such epidemiology, when applied to an eradication programme, ceased to be a purely theoretical enterprise and became an operational factor of paramount importance to success.

Problems existed in the Eastern Mediterranean Region, some technical, depending on the ecology of vector or man, and others caused by the incomplete application of certain criteria. The incomplete elimination of malaria areas in a country was quite common and often delayed eradication because

areas thought non-malarious later turned out to be malarious. Other problems were the inadequate planning of attack measures due to incomplete evidence in the preparatory phase; incomplete coverage by routine observations; the failure to use proper epidemiological measures; the non-observance of certain standards such as the number of examinations necessary for total coverage, or the maximum tolerable number of parasites in the consolidation phase. The failure to enlist the cooperation of the general health services was a shortcoming of epidemiology in so far as it was responsible for making the general health services aware of their important part in the malaria eradication campaign.

All those tasks might seem to call for a prohibitive number of high calibre professional staff. In fact, while a first class brain was essential for the planning phase, and in the attack phase to deal with unexpected problems, the routine epidemiological assessment methods designed by the Expert Committee on Malaria and widely recommended could be handled by semi-skilled staff, of which there was no shortage.

Epidemiological refinements were of little use if basic routine methods were not applied on a total coverage basis. Epidemiological data provided the essential guiding lines for the successful implementation of malaria eradication programmes, including the training of general health personnel for their role in the maintenance phase.

Dr. GJEBIN (Israel) said it was gratifying to note the progress in the Region and the fact that about 170 millions out of a population of 228 millions under malaria risk were now free or nearly free from the disease or were included in pre-eradication programmes. In the past year, the population covered by all methods had increased and more people had entered the maintenance phase. Great progress had been made in Israel, Jordan, the Lebanon and Syria, and many countries were making concentrated efforts to eliminate existing foci.

He re-emphasized the importance of close liaison with the general health services and the gradual stepping up of their participating in malaria eradication. Malaria workers had often found it difficult to obtain proper support from the health workers in the final stages of eradication. It was becoming increasingly evident that steps must be taken to improve coordination between general health and malaria services, for the general health services would have the responsibility of constant vigilance once malaria had been eradicated. Constant vigilance and active cooperation by all medical and para-medical personnel were vital. There was room for improvement in the detection of imported malaria cases, in epidemiological investigation, and the adoption of immediate measures to stop transmission. Ways should be found of giving the general health services more responsibility in the various phases of malaria eradication programmes.

In the course of a malaria eradication programme, co-ordination and cooperation, both within the country and between countries, became of increasing importance. The Regional Director had stressed in his report the importance of cooperation between countries, and it was regrettable that Israel cooperated only with Jordan, and that on a limited scale. Eradication would be greatly helped by cooperation with other countries, since a country could not be considered free from malaria until sufficient neighbouring areas had reached the same status and official international measures had been introduced. To that end, international cooperation and coordination was needed and that was where WHO could be of assistance.

Since 1964, most of Israel had been in the maintenance phase. The anti-malaria and eradication staff were integrated administratively in the existing central, regional and local public health services. Good working relations existed between the general health services and the malaria eradication staff, and much of the eradication work was done by the health services. Special steps had been taken to prevent the import of malaria cases - one of the main problems in the programme - and the re-introduction of malaria by visitors, people returning from technical assistance missions, students, and immigrants. Measures included haemotological examinations, curative treatment and drug chemoprophylaxis. He was glad to note from page 26 of the Regional Director's report that a similar situation existed in the Lebanon and that the prevention of imported malaria was becoming an increasingly important problem. He thanked the Regional Director for his informative remarks.

The CHAIRMAN invited the Committee to adopt the following draft resolution:

"The Sub-Committee,

Having studied the document submitted by the Regional Director on the Epidemiological Aspects of Malaria Eradication in the Eastern Mediterranean Region;

Having also read with attention the information provided in the Regional Director's Annual Report on malaria eradication programmes;

Further considering the recommendations included in the Report of the WHO Inter-Regional Conference on Malaria in the Eastern Mediterranean and European Regions, held at Tripoli, Libya, 28 November - 5 December 1964, and emphasizing the importance of such international and inter-regional meetings which permit specialists engaged in malaria activities to meet together and exchange views;

Noting with satisfaction the progress made in the malaria eradication and pre-eradication programmes of the Region and particularly the improvements witnessed in the surveillance operations of the advanced eradication programmes;

Noting the technical problems encountered in some of the eradication programmes which have hindered their advancement;

Recognizing the important role that rural health services should play in malaria eradication and pre-eradication programmes;

Realizing the danger of reintroduction of malaria into already freed areas either from within the country or from abroad;

1. URGES governments to continue to provide the required support to malaria eradication and pre-eradication programmes;

2. URGES governments undertaking malaria eradication programmes to accelerate the development of rural health services towards the timely taking-over of vigilance responsibilities as the eradication programmes advance to the maintenance phase, and governments undertaking malaria pre-eradication programmes to give priority to the development of rural health services in order to prepare the country for an early commencement of the eradication programme, and urges the international and bilateral agencies to provide the maximum possible assistance to such developments;

3. EMPHASIZES the need for special studies in problem areas, aiming at a solution to the technical problems by applying newer insecticides or using supplementary attack measures to achieve interruption of transmission, and requests the Regional Director to provide the necessary assistance in these studies;

4. STRESSES the importance of retaining the achievements reached in the maintenance phase areas and urges governments to take appropriate measures for the prevention of reintroduction of the disease;

5. STRESSES the importance of inter-service coordination and the importance of training health personnel in malaria eradication and malaria personnel in other health aspects, and reiterates the need for inter-country coordination of planning and operational activities of Member States, especially in border areas;

6. ENDORSES the recommendations made at the WHO Inter-Regional Conference on Malaria held in Tripoli, Libya, November/December 1964, and calls upon Governments to implement these recommendations."

The draft resolution was adopted.

(b) Statistical Data required for National Health Planning (Document EM/RC15/5)

The REGIONAL DIRECTOR introduced the document, and recalled that in his report he had expressed satisfaction that many countries of the Region had drawn up health plans and others were in the process of doing so, with the help of WHO where necessary. Health planning was a complex process requiring much data, the collection of which needed good statistical services. Unfortunately, very few countries had the requisite services. It was vital in health planning to determine priorities, but that could not be done without data on health needs and on morbidity and mortality. The Regional Office had sent a questionnaire to countries in the Region and their replies were summarized in Annex 1.

National Health planning had been the subject of the Technical Discussions at the Eighteenth World Health Assembly and it had been agreed that certain data was essential, including demographic data, vital statistics, morbidity data, inventory of public and private health institutions, training institutions, health man-power statistics, national economic background information, and financial allocation for health services. The last item was often difficult to obtain in the Eastern Mediterranean Region since in some countries a large proportion of support came from voluntary sources.

The main purpose of the report was to emphasize the need for adequate data in the preparation of satisfactory and comprehensive plans which would provide for all requirements and be adjustable to changing needs.

Dr. GJEBIN (Israel) expressed satisfaction with the report, which set out concisely what was required for health planning. In that connexion, he recalled the back-ground paper prepared by Sir John Charles and the comments of Dr. Evang.

As the Regional Director had said, many countries were not very advanced in health planning and the Regional Office was to be congratulated on having brought up the question again. He hoped it would lead to an advance, especially in countries which hitherto had never carried out a census or even made an estimate of their population. According to United Nations official statistics only two countries in the Region, Aden and Israel, were classified as satisfactory in that respect. He hoped that discussions would result in satisfactory progress so that all the countries of the Region would be able to plan their health programmes.

The CHAIRMAN invited the Committee to adopt the following draft Resolution:

"The Sub-Committee,

Having studied the document on statistical data required for national health planning;

Noting with satisfaction that most governments of the Eastern Mediterranean Region, in pursuance of the resolution of the resolution of the Seventh Regional Committee (EM/RC7A/R.20), September 1957, have prepared national health plans for specific periods on a long-term basis;

Considering that planning for socio-economic development including health is likely to assume increasing importance in the future to ensure effective utilization of human and material resources and orderly development of health services;

Being aware of the fact that realistic planning for health purposes cannot be undertaken without reliable data on demography, vital and health statistics, health conditions, health establishments, health personnel, health services provided and financial and manpower resources;

Reiterating the resolution on vital health statistics approved by the Twelfth Regional Committee (EM/RC12/R.7), October 1962,

1. URGES Member States to pursue their efforts for:

(a) improving the collection and processing of statistical information on the prevailing health conditions, available medical manpower and financial resources, utilization of health services and services provided by health institutions in their countries, and training of statistical personnel;

(b) making provisions in their development plans for improving/establishing statistical and health programming and evaluation units as a part of the central health organization;

2. RECOMMENDS that the Regional Director continue assistance to Member States for promoting health statistics and health planning by means of education and training in the subjects, meetings of health statisticians, preparation of manuals on health statistics and their uses, and when requested to advise on development of statistics and planning organization."

The draft Resolution was adopted unanimously.

The meeting rose at 5.35 p.m.